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2400.00.00 NON-FINANCIAL REQUIREMENTS

This chapter contains the various non-financial eligibility requirements which must be considered, dependent upon the types of assistance for which an individual is applying. The major sections in the chapter are as follows:

Citizenship/Immigration Status (Section 2402);

Requirement to Provide a Social Security Number (Section 2404);

Residency (Section 2406);

Identity (Section 2408);

Age (Section 2410);

Blindness or Disability (Section 2412);

SSI Status (Section 2414);

Medicare Status (Section 2416);

Deprivation (Section 2418);

Residence in the Home of a Specified Relative (Section 2420);

Institutional Status (Section 2422);

Level of Care/Preadmission Screening (Section 2424);

Pregnancy (Section 2426);

Newborn Status (Section 2428);

Requirement to File for Other Benefits (Section 2432);

Assignment of Medical Rights (Section 2434);

Child Support Participation (Section 2436);

Work Registration (Section 2438);

Cooperation with Quality Control (Section 2440);

Intentional Program Violation (Section 2442);

Child Care Referrals (Section 2444);

Strike Participation (Section 2446);

(Reserved) (Section 2448);

Personal Responsibility Agreement (Section 2450);

TANF Benefit Time Limits (Section 2452);

Self-Sufficiency Plan (Section 2454);

Sanctions (Section 2456); and

Footnotes for Chapter 2400 (Section 2499).

The requirements for each of these non-financial factors and their verification requirements are described in this chapter.

2402.00.00 CITIZENSHIP/IMMIGRATION STATUS

In order to be eligible for assistance, an individual must be:

A citizen of the United States; or

a U.S. non-citizen national (a person born in an outlying possession of the United States, American Samoa or Swain's Island);

an immigrant who is in a qualified immigration status as defined in Section 2402.20, and who meets the specific requirements of each program; or

an individual who meets other specific requirements for a specific program as defined in the following sections.

2402.05.00 DECLARATION OF CITIZENSHIP/IMMIGRATION STATUS

The policy stated in this section does not apply to MA X.

During the eligibility interview, the interviewee is questioned about various personal characteristics of each individual in the assistance group, including whether the person under consideration is a citizen of the United States. This information is entered on the ICES screen which deals with the individual attributes of the AG: AEIIA.

If the interviewee states that an individual is a citizen, "Y" is entered on the screen. An "N" in the citizenship field for any AG member will produce screen AEICZ which collects specific data about the immigrant status of the non-citizen.

Upon completion of the interview, and prior to authorization of the case, the Application for Assistance Part 3 Client Certification, FI-2403, is to be printed for the interviewee's signature. The signature page includes a statement informing the interviewee that by signing the application, he is certifying under penalty of perjury that all of the information he provided about the citizenship or alien status of the AG members is complete and correct to the best of his knowledge and belief.

When an AG indicates inability or unwillingness to provide documentation of immigration status for any AG member, that individual without documentation must be considered as an undocumented immigrant for Food Stamps and TANF.

DFR staff will not report any information about an immigrant applying for Food Stamps and/or TANF to the United States Citizenship and Immigration Service (USCIS) unless the USCIS has established that the immigrant is unlawfully present in the United States through a formal review process conducted by USCIS.

A Systematic Alien Verification Entitlements request and response of inaccurate documentation does not serve this purpose. An applicant's statement or any other third party information does not constitute a determination of unlawful status. A worker should not seek to obtain an immigrant's status unless the immigrant requests help in obtaining this verification.

A refusal to sign the declaration will result in the ineligibility of the entire AG.(f1)

2402.10.00 DEFINITION OF U.S. CITIZENSHIP

To be considered a U.S. citizen, an individual must meet one of the following conditions:

be born in the U.S. or a U.S. territory (2402.10.05);

be a naturalized citizen (2402.10.10); or

be born abroad to a U.S. citizen and meet specified criteria (2402.10.15).

2402.10.05 Born In The U.S. Or A U.S. Territory

An individual is considered born in the U.S. or a U.S. territory if either of the following conditions are met:

the individual is born in one of the United States or the District of Columbia (D.C.); or

the individual is born in one of the following current territories:

- Puerto Rico;
- Northern Marianas;
- American Samoa;
- Harcon Tract;
- Swain's Island;
- Guam; or
- the Virgin Islands.

2402.10.10 Naturalized Citizens

An individual is considered a naturalized citizen when U.S. citizenship is gained after his birth either:

Through individual naturalization; or
derived from a naturalized parent.

Women who could have been lawfully naturalized and, prior to September 22, 1922, were married to citizens, or were married to aliens who became citizens before that date, automatically become citizens. An alien married to a U.S. citizen on and after September 22, 1922, must apply for naturalization to become a U.S. citizen.

2402.10.15 Children Born Abroad To U.S. Citizens

In most instances, citizenship is acquired at birth if at least one of the natural parents is a U.S. citizen. It should not be presumed, however, that the child was a citizen at birth unless at least one citizen parent was a previous U.S. resident or lived in a U.S. territory. (Refer to Section 2402.10.05)

For children born before May 24, 1934, U.S. citizenship may only be established in this way for legitimate children through their citizen father who would have had to meet the above-mentioned residency requirement. For children born after May 24, 1934, either parent's U.S. citizenship and residency may serve as the basis for the foreign-born child's own U.S. citizenship.

2402.10.20 Citizenship After Birth

Children become U.S. citizens after birth when:

Both parents become U.S. citizens after the child's birth, but before the child reaches 18; or

one parent becomes a U.S. citizen, the other alien parent is deceased, and the child is under 18.

2402.15.00 VERIFICATION REQUIREMENTS FOR U.S. CITIZENS

Verification of citizenship is required for the TANF, Medicaid, and Child Care programs.

For the Food Stamp program, a declaration of U.S. citizenship (whether by birth or naturalization) is accepted, unless the information is questionable. Questionable information should always be verified.

2402.15.05 Verification Sources For U. S. Citizens

Acceptable sources of verification for U.S. citizens include, but are not limited to, the following:

physician's record of birth;

birth or hospital certificates showing U.S. birth;

Form FS-545 (Certification of Birth);

Form I-197 (U.S. Citizen I.D. card);

religious documents, such as a baptismal record, showing birth in the U.S.;

SSA records;

County Department of Health birth records;

a census indicating age and citizenship;

U.S. passport;

Certificate of Citizenship or Naturalization;

Resident Citizen Cards;

Form FS-240 (Report of Birth Abroad of a Citizen of the United States);

Form I-97 (Consulate Report of Birth or Certification of Birth);

Form 179 (U.S. Citizen I.D. Card); or

INS correspondence

A signed statement from another person who is a citizen, stating that the member in question is a U.S. citizen, is also an acceptable verification source if other verification is not available.

2402.20.00 IMMIGRANTS

Individuals who are not citizens of the United States may qualify for assistance based on their status granted by the U.S. Citizenship and Immigration Service (USCIS). Listed below are "qualified" immigrants as defined in Federal law. However, the eligibility of these immigrants varies among the programs and is based on certain factors as explained in the following sections. Do not authorize or deny assistance based solely on this list. Read the following sections to understand the distinctions in program eligibility and benefits. Immigrants in any other INS classification are not eligible for Food Stamps, TANF, and full coverage Medicaid, but can be eligible for emergency Medicaid coverage.

1. Lawful Permanent Resident under the Immigration and Naturalization Act (INA).
2. Asylees under Section 208 of the INA.
3. Refugees under Section 207 of the INA.
4. Parolees under Section 212(d)(2) of the INA if paroled for at least one year.
5. Persons whose deportation is withheld under Section 243(h) of the INA.
6. Conditional entrants under Section 203(a)(7) of the INA in effect prior to April 1, 1980.
7. Cuban and Haitian entrants.
8. Amerasians admitted pursuant to Section 584 of P.L. 100-202 and amended by P.L. 100-461.

NOTE: For Food Stamps, aliens who are otherwise ineligible for Food Stamps are not made eligible for Food Stamps because they receive SSI. That is, the ineligibility status of an alien takes precedence over categorical eligibility.

The eligibility provisions are mandated by Federal law: Title IV of the Personal Responsibility and Work Opportunities Reconciliation Act (P.L. 103-193) as amended by the Balanced Budget Act of 1997 (P.L. 105-33), the Agricultural Research, Extension and Education Reform Act of 1998 (P.L. 105-185), and the Farm Security and Rural Investment Act of 2002 (P.L. 107-171).

2402.20.05 Lawfully Admitted For Permanent Residence

Under the Immigration and Nationality Act (INA), a Lawfully Admitted Permanent Resident (LPR) is one who has been lawfully accorded the privilege of permanently residing in the U.S. as an immigrant in accordance with Section 101(a)15

and 101 (a)20 of the INA, with such status not having changed since admission.

Lawful Permanent Residents should present INS Form I-551 as documentation of their immigration status. Caseworkers should check the coding on the I-551 for code, RE-6, RE-7, RE-8, or RE-9. This denotes entry as a refugee with subsequent adjustment to LPR status. Refer to Section 2402.20.15 concerning eligibility of refugees.

Lawful Permanent Residents who were residing in the U.S. prior to 8/22/96 are eligible for full Medicaid coverage. However, LPRs who enter the U.S. on and after 8/22/96 are eligible for emergency coverage only, for 5 years unless they are honorably discharged veterans or in active military duty. (Refer to Section 2402.20.45.) At the end of the 5 year period, LPRs can be eligible for full coverage.

A lawful permanent resident is eligible for Food Stamps if one or more of the following conditions exist:

The individual has 40 Qualifying Quarters of employment or could be credited with such Qualifying Quarters of employment (See Sections 2402.20.05.10 through 2402.20.05.20 for instructions about how to calculate Qualifying Quarters;

The individual has legally resided in the U.S. for 5 years (Policy Effective 4/1/03);

The individual who is a veteran with an honorable discharge for reasons other than his/her alienage;

The individual is the spouse or dependent of a person whom has 40 qualifying quarters or is a veteran with an honorable discharge and lives with that person;

The individual is a child under age 18 legally residing in the U.S. (Policy Effective 10/1/03);

On or after 11/1/98, the individual had LPR status on 8/22/96 and was age 65 or older at that time; or

The individual is now blind or disabled based upon criteria in IPPM 3210.10.25.05.

Lawful Permanent Residents who were in the country prior to 8/22/96 may receive benefits if they have 40 qualifying quarters of employment or can be credited with such qualifying quarters of employment. (Refer to Sections 2020.20.05.05 through 2402.20.05.15 regarding determining 40 quarters). LPRs who were receiving Food Stamps as of 8/22/96 did not have to meet the 40 quarter requirement until their first redetermination or verification of

quarters worked subsequent to April 1, 1997 but no later than January 31, 1998.

A qualifying quarter may include time worked by a parent of an alien while the alien was under 18 and a quarter worked by a spouse during their marriage if the alien remains married to the spouse or the spouse is deceased.

A qualifying quarter belonging to a parent(s) may be credited to the parent, the parent's spouse **and** to one or more children.

In addition, a lawful permanent alien of any age can be credited with qualifying quarters earned by a parent through the quarter the alien attains age 18, whether or not the parent(s) is currently living.

> Example:
>
> A lawful permanent resident couple and their two children, who are also lawful permanent residents, (one age 12 and the other age 23) all apply for Food Stamps. Each member of the couple has earned 20 qualifying quarters for work done more than 5 years earlier, before the older child turned age 18. All four applicants meet the 40 qualifying quarter's eligibility requirement based on the couple's combined 40 qualifying quarters.

Spouses cannot get credit for quarters of a spouse when the couple divorces prior to a determination of food stamp eligibility. However, if eligibility is determined based on the quarters of coverage of the spouse and then the couple divorces, the non-citizen's eligibility determination must then be made without crediting the non-citizen with the former spouse's quarters of coverage.

Beginning January 1, 1997 any quarter in which the LPR received TANF, FS, SSI or Medicaid (except emergency coverage) is not counted as a qualifying quarter.

Lawful Permanent Residents who were residing in the U.S. prior to 8/22/96 are eligible for full Medicaid coverage. However, LPRs who enter the U.S. on and after 8/22/96 are eligible for emergency coverage only for 5 years unless they are honorably discharged veterans or in active military duty. (Refer to Section 2402.20.45). At the end of the 5 year period, LPRs can be eligible for full coverage.

Lawful Permanent Residents who were residing in the U.S. prior to 8/22/96 are eligible for TANF. However, LPRs who enter the U.S. on and after 8/22/96 are not eligible for

TANF unless they are veterans or in active military. (Refer to Section 2402.20.45).

Lawful Permanent Residents should present INS Form I-551 as documentation of their immigration status. Caseworkers should check the coding on the I-551 for code, RE-6, RE-7, RE-8, or RE-9. This denotes entry as a refugee with subsequent adjustment to LPR status. Refer to Section 2402.20.15 concerning eligibility of refugees.

2402.20.05.05 American Indians Born In Canada

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

A North American Indian born in Canada may freely enter and reside in the U.S. and is considered to be lawfully admitted for permanent residence if he is of at least 50% American Indian blood. This does not include the spouse or child of such an Indian nor a non-citizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least 50% American Indian blood.

Sources of verification are:

birth or baptismal record issued on a reservation;

tribal records;

letter from the Canadian Department of Indian Affairs; or

school records

2402.20.05.10 Obtaining 40 Qualifying Quarter Verification (F, C)

During the interview the worker must obtain information to determine whether the applicant/recipient of immigrant status has worked or obtained credit for 40 quarters of employment. Since the applicant's work and work by his/her parents and/or spouse can be combined to attain the 40 quarters, it is necessary to obtain information to determine the proper relationships, the date of birth of the applicant and certain identifying information.

The quarters of the following individuals may count in the 40 quarter determination.

- the applicant
- the applicants natural/adoptive or step parents (while the applicant was under age 18, including quarters worked before the child was born). If a step parent relationship ends based on martial

status the quarters of the step parent are no longer applicable.
- the current spouse
- former spouse (only if deceased).

The worker must also determine if it is possible for the applicant to meet the 40 quarter requirement by asking how many years each relevant individual (persons who quarters may count) and the applicant have lived in this country, then add the years together. If the total is less than 10, the applicant cannot meet the 40 quarter requirement and will be determined to be ineligible.

Then, determine how many years in total the applicant and relevant individuals have worked in the U.S. Four quarters in each year can be credited to the applicant and each relevant individual. Quarters of work not covered by Title II of the Social Security Act may be counted in the determination.

The 40 quarter verification will be completed by ICES via a match with the Social Security Administration. A Form-3288, Consent for Release of Information, for a relevant parent or spouse who is not an AG member, is no longer required.

Aliens are also deemed eligible when the State or applicant has requested verification/information from a Federal agency, and verification is pending from the agency.

2402.20.05.15 ICES 40 Quarter Match (F)(C)

If an applicant is coded on AEICZ as "PR" (legal permanent resident), ICES will automatically request the qualifying quarter verification from SSA for the applicant and the spouse, and parent(s) listed on AEIID.

If there are relevant individuals (spouse, deceased spouse, or parents) not in the home for whom data must be obtained, complete ICES screen AEIAR with the following information for the spouse/parents:

- full name of individual (non-AG member spouse/parent)
- date of birth
- social security number
- sex of individual
- relationship to applicant

This screen is not in the driver flow and must be accessed by entering AEIAR in the "NEXT TRAN" and the case number or applicant's RID in "PARMS".

On Friday of each week, ICES sends SSA a file containing all the individuals that have been entered in the last week

requesting the 40 quarter information. SSA sends the file back with the information the next week and ICES processes it on Fridays. The schedule may vary if problems result. The following Monday the worker will receive alert 891 (REV SSA 40 QTR COVG DATA - DEQE) when the information is available.

DEQE is accessed with a PARM of the applicants RID or SSN. A match date may be used as an option.

DEQE has three main sections. The first is the ICES demographics section where all recipient data is kept. This section also shows the recipient's relatives match with their relationship. The summary section will show the grand total of all quarters of coverage of all related individuals. The yearly detail table is last showing each year and the coverage information by quarter for every year from the most recent available back through 1937.

There will be a screen for the applicant and each relevant individual. The applicant's screen will show the total covered quarters for himself passed from SSA plus covered quarters calculated by data exchange from IDWD.

PF7 and PF8 may be used to scroll through the years and PF6 to scroll through the matches and history.

The process will also compare current wage information for the most recent two years with Workforce Development wage information for the recipient.

All quarters verified as a qualifying quarter during the most recent two years will be added as "WAGE QC".

The worker must compare the quarters with other information obtained during the interview regarding receipt of other public assistance benefits (Medicaid, Food Stamps, TANF or SSI) received in a month of a qualifying quarter. Those months must not be included in the 40 quarter count. Documentation should be entered in CLRC regarding any quarter not considered.

Any quarter displaying with "WAGE QC" for a parent or spouse of the applicant/recipient must be reviewed to determine if it is a countable quarter, that is, the quarter was in a time when the child was under 18 if the parent has the quarter, or the applicant was married if the spouse has the quarter.

Any number of quarters shown as MINIMUM NUMBER QC'S 1937-1950 should be added to the total covered quarters for a final total.

After the 40 quarter determination is complete, the worker is to enter the lawful permanent resident alien's status on screen AEIER. The codes for the status are obtained on table TIER.

The worker must also enter the total number of qualifying quarters on this screen.

If the client requests review by Social Security, that should be entered on AEIER and the client will be able to participate up to 6 months pending the completion of the review.

AGs which contain lawful permanent residents who do not have 40 qualifying quarters of income and are determined ineligible should have their qualifying quarters re-evaluated at each redetermination. This will be an off-line determination made by adding the quarters of employment obtained since the last determination to the number previously recorded. The total should be documented on CLRC and updated with each redetermination.

If all members of an AG are determined to be ineligible because the individuals do not have 40 qualifying quarters and later reapply, another data match will automatically occur if AEICZ is coded with the alien status of PR.

2402.20.05.20 Reconciling 40 Qualifying Quarter Verification (F, C)

If DEQE shows QUESTION MAXIMUM NBR QC's 1937-1950, and the amount is needed to meet the 40 quarter determination, the individual must request a review by SSA.

If DEQE displays one of the 3 following messages the client must also request a review by SSA:

- CASEWORKER TO DETERMINE
- EARNINGS RECORD NOT FOUND
- RECORD NOT PROCESSABLE

If the individual believes that the work he/she performed was covered and is not counted for a past year, SSA is responsible for investigating the discrepancy and correcting the record.

Refer the individual to the local Social Security office to resolve the issue.

A copy of screen DEQE should be given to the individual along with the SSA contact form.

SSA will give the individual a form to verify that a request for a review has been made.

If the information from a rematch is not obtained within 60 days, call the local SSA office.

If the information is obtained and shows that the individual is not eligible based on the 40 quarters a claim will be needed for the months during which benefits were received pending the verification.

When an applicant cannot meet the 40 qualifying quarter exemption using covered earnings or Medicare only Federal, State, or local wages but alleges that he/she had additional work that is not shown on the data match, determine if qualifying quarters are missing from the record.

If qualifying quarters are missing, obtain the following information:

a. Name and address or employer
b. Dates of employment
c. Amount of earnings
d. Type of business or self-employment
e. Rate of pay
f. Work performed

Request the AG obtain evidence to credit the qualifying quarters. Evidence may include, but not be limited to: Form W-2 and W-2c, employer prepared statements, IRS copy of tax returns, union records, pay envelopes, vouchers and individual personal records.

When verification is obtained and submitted by the AG, contact the Help Desk with the information for assistance in determining the number of qualifying quarters that can be credited.

Since 97 percent of all employment is now covered under the Social Security Act, these instances of non-covered employment should be rare.

2402.20.10 Conditional Entrant Refugee

Section 203(a)(7) of the Immigration and Nationality Act (INA) in effect before April 1, 1980 provides conditional entrant refugee status for persons who, because of persecution or fear of persecution on account of race, religion, or political opinion, have fled from a Communist or Communist-dominated country or from the area of the Middle East or who are refugees from natural catastrophes. (Section 203(a)(7) of the INA was replaced by Section 207 effective April 1, 1980.)

Conditional entrant refugees are eligible for Food Stamps as would be qualified aliens whom have had 5 years in qualified status.

Individuals with this status can be eligible for full Medicaid coverage and also for TANF. (Note a person entering the U.S. on and after 8/22/96 will not be given this INS status, since it is no longer in effect.)

Verification is established by viewing INS Form I-94, Arrival-Departure Record, bearing the stamped legend "Refugee - CONDITIONAL ENTRY" and citing the section of the INA under which they were admitted, or INS Form I688B annotated "274a.12(a)(3)" or I-766 annotated "A1", "A3".

2402.20.15 Refugees Under Section 207

Individuals admitted as refugees under Section 207 of the INA are eligible for Food Stamps, TANF and full coverage Medicaid once they obtain this status. Refugees usually adjust to Lawful Permanent Resident status after 12 months in the U.S.

Refugees will have INS Form I-94 annotated with a stamp showing entry as refugee under Section 207 and date of entry, INS Form I-688B annotated "274a.12(a)(3)", or I-766 annotated "A3". INS Form I-571 also indicates status as a refugee, but does not reflect the date of admission. If Form I-94 is not available, verification must be obtained from the USCIS.

2402.20.20 Parolees Under Section 212(d)(5)

Individuals granted parole into the country under Section 212(d)(5) of the INA would be eligible for Food Stamps if lawfully residing in the U.S. and;

In receipt of disability benefits; or

Has 40 qualifying quarters; or

Has 5 years of qualified status; or

Is under age 18; or

Is a veteran or in active military duty, including spouses and dependent children; or

Was born on or before 8/22/31.

Individuals who were granted parole under Section 212(d)(5) for <u>at least one year</u>, and who entered the U.S. prior to 8/22/96 can be eligible for full Medicaid coverage and also for TANF. Those who enter the U.S. on and after 8/22/96 are not eligible for TANF and can be eligible for emergency Medicaid only, unless they are veterans or in active military duty. Veterans and military personnel can be eligible for TANF and full Medicaid coverage. (Refer to

Section 2402.20.55 concerning veterans and active duty military.)

Verification is established by viewing INS Form I-94 annotated with a stamp showing granting of parole under Section 212(d)(5) of the INA and a date showing granting of parole for at least 1 year- or Form I-688B annotated "274a.12(a)(4), 274a.12(c)(11) or Form I-766 annotated "C11" or "A4".

2402.20.25 Asylees Under Section 208

Individuals granted asylum under Section 208 of the INA are eligible for Food Stamps for 7 years after they obtain this status.

Asylees can be eligible for TANF and full coverage Medicaid.

Verification of the asylee status includes INS Form I-94 annotated with a stamp showing granting of asylum under Section 208 of the INA or a grant letter from the Asylum Office of the INS. Forms I-688B annotated "274 a.12(a)(5)" or I-766 annotated "A5" indicate status as an asylee. The date of the form does not reflect when the status was granted. Request Form I-94, the grant letter, or the person's copy of a court order. Verify with USCIS if none of these are available.

2402.20.30 Deportation Withheld Under Section 243(h)

Individuals who have had deportation withheld by an Immigration Judge under Section 243(h) of the INA are eligible for Food Stamps for 7 years after they obtain this status. However, if these individuals meet one of the conditions that make qualified immigrants eligible (such as qualified status for 5 years), they would be eligible indefinitely.

Individuals with a deportation withheld order are eligible for TANF and full coverage Medicaid.

An immigrant who has had deportation withheld under this status will have an Order of an Immigration Judge showing deportation withheld under Section 243(h) of the INA and date of the grant. INS Forms I-688B annotated "274a.12(a)(10)" or I-766 annotated "A10" indicate deportation was withheld under Section 243(h) or removal withheld under Section 241(b)(3), but normally do not reflect the date of withholding. Request the person's copy of the court order. If not available, verification must be obtained from the USCIS.

2402.20.35 Amerasian Immigrants

Certain Amerasians from Vietnam, with their close family members, have been allowed entry into the U.S. in immigrant status through the Orderly Departure Program beginning March 20, 1988.

They can be eligible for full coverage Medicaid, Food Stamps and TANF. Acceptable documentation of this status is:

- I-94 indicating codes AM1, AM2, or AM3;
- I-551 indicating codes AM6, AM7, AM8;
- Vietnamese Exit Visa, Vietnamese Passport, or U.S. passport if stamped by the USCIS with the codes AM1, AM2, or AM3;
- Temporary I-551 stamp in foreign passport; or
- I-571 Refugee Travel Document

2402.20.40 Cuban and Haitian Entrants

Cuban and Haitian entrants, as defined in Section 501(e) of the Refugee Education Assistance Act of 1980, can be eligible for Food Stamps, full coverage Medicaid and TANF.

2402.20.43 Hmong/Lao Immigrants (F)

Effective 11/1/98, any individual lawfully residing in the United States who was a member of the Hmong or Highland Laotian tribe at the time that the tribe assisted the United States personnel during the Vietnam era is eligible for Food Stamps.

The spouse and un-remarried dependent child(ren) of this immigrant are also eligible. The un-remarried surviving spouse of a deceased individual with this status is eligible as well.

2402.20.44 Cross Border Native Americans(F)

Native Americans with treaty rights to cross the U.S. borders with Canada and Mexico, regardless of whether they were born on the Canadian or Mexican side of the border are eligible for Food Stamps effective 11/1/98.

2402.20.45 Veteran or Active Duty Member of the Armed Forces

As explained in the previous sections, immigrants with certain USCIS classifications who would otherwise be subject to assistance limitations can be eligible if they are; veterans, are on active duty in the military, or have served minimum active duty service requirements, or are spouses or dependent children of veterans or military personnel who die during active military duty. The exemption for veterans also applies to individuals who served in the Philippine

Commonwealth Army during World War II or as Philippine Scouts following the war.

An eligible veteran is a person who served in the active U.S. military, naval, or air service, and was released with a discharge characterized as honorable and not on account of alienage. Veterans should have received a full copy of DD Form 214 (Certificate of Release of Discharge from Active Duty) that contains the necessary information. An honorable discharge is denoted by the entry of "Honorable" in the "Character of Service" block of DD Form 214. If the evidence characterizes the discharge as anything other than "Honorable", such as "Under Honorable Conditions", the individual and family members cannot be determined eligible based on the veteran exception. Eligibility based on veteran status cannot be established if the reason for discharge was based on alien status, lack of U.S. citizenship or other "alienage" reasons, or if the "Separation Code" block contains an entry JCP, KCP, SCP, or YCP. Those codes establish discharge based on alienage. If the individual states that he or she meets the veteran requirements but is unable to present the appropriate discharge papers as documentation, the caseworker should contact the Veterans Affairs Regional Office.

The eligibility exception for veterans also applies to the Hmong and other Highland Lao tribal people who fought on behalf of the U.S. Armed Forces during the Vietnam conflict.

Persons who fulfill the minimum active duty service requirements or their un-remarried surviving spouse and dependent children are also exempt from other alien requirements. Minimum active duty served by a person who initially enters service after 9/7/80 is 24 months of continuous active duty or the full period for which the person was called or ordered to active duty.

A person who is on active duty in the U.S. Armed Forces (other than active duty for training) is also not subject to the assistance limitations placed on immigrants in his particular classification. Documentation of active duty status is the individual's service identity card (U.S. Form DD-02) which should be a green service identity card marked "Active" after the form number. A red service identity card marked "Reserved" is not evidence of active duty unless supported by a copy of the individual's current orders showing active duty, and not active duty for training. A blue (retiree) or beige (dependent) card is not evidence of active duty.

2402.20.47 Battered Alien Spouse/Child (F)

Certain aliens who have been subjected to battery or extreme cruelty in the United States by a family member with whom

they resided are considered qualified aliens. Battered aliens who are not eligible under any other qualified status may be eligible for Food Stamps if they are lawfully residing in the U.S. and meet one of the following conditions:

Are in receipt of disability benefits, OR

Have 40 qualifying quarters, OR

Have 5 years in qualified status, OR

Are under age 18, OR

Were born on or before 8/22/31, OR

Are a veteran with a honorable discharge or who are on active duty. Applies to spouse and dependent children of veterans and active duty personnel.

A battered alien with a connection to one of the preceding conditions also must meet four requirements as listed below.

Following are the four requirements which must be met to make a battered alien/child or parent a qualified alien:

(1) The USCIS (United States Citizenship and Immigration Service) or the EOIR (Executive Office for Immigration Review) has granted a petition or application filed by or on behalf of the alien, the alien's child or the alien child's parents. To prove this, the applicant needs to present documentation of an INS-130 or an INA-360. After this is provided, INS must be contacted to verify there is an approved petition or application pending under 204(a)(1)(A)(B) or 244(a)(3) of the Immigration and Nationality Act; (contact the Help Desk for assistance in this requirement);

(2) The individual must have been battered or subjected to extreme cruelty in the United States by a spouse or a parent, or by a member of the spouse or parent's family residing in the same household as the alien and the spouse or parent consented to, or acquiesced in, the battery or cruelty;

The phrase "battered or subjected to extreme cruelty" includes, but is not limited to being victim of any act or threatened act of violence, including any forceful detention, which results or threatens to result in physical or mental injury. Psychological or sexual abuse or exploitation, including rape, molestation, incest (if victim is a minor), or forced prostitution are considered

acts of violence.

"Member of the spouse or parent's family" includes any person related by blood, marriage, or adoption to the spouse or parent of the alien, or any person having a relationship to the spouse or parent that is covered by the civil or criminal domestic violence status of the state.

(3) There is a substantial connection between the battery or extreme cruelty and the need for Food Stamps; and

In determining whether or not there is a substantial connection between the battery or cruelty and the need for benefits the worker should look at some of the following questions as guidance:

Will the benefits enable the applicant/child or parent to become self-sufficient?

Will the benefits enable the abused individual(s) to escape the abuser?

Are the benefits needed due to a loss of financial support resulting from the applicant's, his or her child and/or his or her parent's separation from the abuser?

Are the benefits needed for medical attention or mental health counseling as a result of the battery/abuse or cruelty?

Are the benefits needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser?

(4) The battered/abused alien, child or parent no longer resides in the same household as the abuser.

An applicant is not technically considered a qualified alien eligible for benefits until the battered/abused applicant or child, or parent ceases residing with the batterer/abuser. However, applicants will generally need the assurance of the availability of benefits in order to be able to leave their batterer/abuser and survive independently. Therefore, any relevant credible evidence supporting the claim of non-residency with the batterer/abuser should be accepted. Such examples would include, but not be limited to, a civil protection order requiring the battered/abuser to stay away from the applicant or the applicant's children or parent, employment records, utility or school records, an affidavit from a staff member at a shelter, family member's friends or

other third parties with personal knowledge, or the battered applicant himself or herself if no other sources are available.

If the battered/abused alien meets all four criteria requirements, they are considered to be a qualified alien and eligible for benefits assuming all other eligibility criteria is met.

Qualified battered aliens who are sponsored are exempt from having the income and resources of their spouse deemed in their eligibility determination for a period of twelve months. After expiration of the one year period, alien applicants continue to be exempt from the deeming requirements with regard to the income and resources of the batterer only if the applicant can show that the battery or cruelty has been recognized in an order of a judge or administrative law judge. In addition, a substantial connection between the abuse or battery suffered by the applicant/child or parent and the need for the benefits being applied for must be shown as continuing to exist.

2402.20.48 Victims Of Severe Trafficking In Persons (F)

Victims of trafficking who are non-U.S. citizens are eligible for Food Stamps under the Trafficking Victims Protection Act of 2000 (Public Law 106-386). Severe forms of trafficking in persons is defined as Sex Trafficking which is the recruitment, harboring, transportation, provision or obtaining of a person for the purpose of a commercial sex act induced by force, fraud or coercion, or in which the person is forced to perform such act is under the age of 18 years; or Labor Trafficking which is the recruitment, harboring, transportation, provision or obtaining of a person for labor or services, through the use of force, fraud, or coercion, for the purpose of subjection to involuntary servitude, peonage, debt bondage or slavery. In addition, minor children, spouses and in some cases the parents and siblings of victims of severe trafficking may also be eligible for benefits.

Victims of trafficking are issued T Visas by U.S. Citizenship and Immigration Service (USCIS). Eligible relatives of trafficking are entitled to visas designated as T-2, T-3, T-4 or T-5 (Derivative T Visas). In the case of an immigrant who is awarded a T Visa and who is under 21 years of age on the date the T Visa was filed, Derivative T Visas are available to the alien’s spouse, children, unmarried siblings under 18 years of age on the date on which the alien’s Visa application was filed as well as the parents of the alien victim. In the case of an alien who is awarded a T Visa and was 21 years of age or older on the date the T Visa application was filed, the Derivative T Visas are available to the alien’s spouse and children.

Eligibility for Food Stamps may be verified through the HHS Trafficking Victim's toll-free number (1-866-401-5510). Since the law also confers potential eligibility for TANF, individuals with these Visas are also categorically eligible for Food Stamps.

2402.20.49 Iraqi And Afghani Special Immigrants

Effective December 26, 2007, Public Law 110-161 of the Consolidated Appropriations Act of 2008 granted certain Iraqi and Afghan nationals special immigrant status under section 101(a)(27) of the Immigration and Nationality Act (INA). Individuals and family members granted this special immigrant status maybe eligible for TANF, Food Stamps, Medicaid and Hoosier Healthwise, and/or Refugee Assistance benefits. Iraqi Special Immigrants are eligible for a period not to exceed eight months. Afghani Special immigrants are eligible for a period of eligibility for six months.

Both Iraqi and Afghani special immigrants will either enter the U.S. as Lawful Permanent Residents (LPRs) with the special immigrant visa or will adjust to special immigrant status after entering the U.S. under another immigration status (such as an asylee or parolee). Therefore, unless the immigrant is a qualified alien and is eligible under current program rules, the date of eligibility may or may not coincide with the special immigrant's date of entry.

For TANF and Medicaid/Hoosier Healthwise, these Iraqi and Afghan special immigrants should be treated as refugees. As refugees, these individuals will default to being eligible for refugee cash assistance (ADCQ) or refugee medical assistance (MA Q) if they are determined ineligible for TANF and/or Medicaid/Hoosier Healthwise. However, unlike regular refugees, these special immigrants only retain this special status for the timeframes as identified above – Iraqis for a period not to exceed eight months and Afghanis for a period not to exceed 6 months.

The provision concerning Iraqi Special Immigrants became law on January 28, 2008 and is in effect for five fiscal years. The Afghani Special Immigrant provision is only in effect through September 2008 unless it is extended by law.

2402.20.50 Other Immigrants, Visitors, and Non-Immigrants

Any other immigrants, including those who are undocumented, who are not specified in the previous sections, are not eligible for Food Stamps or TANF. They can be eligible for emergency Medicaid coverage if they meet all other requirements of the category in which they qualify. However, eligibility for emergency services only may not be

approved under the MA 10 category. A child who is undocumented or a visitor or non-immigrant as described in paragraph four below, is not eligible for Hoosier Healthwise Benefit Package C, regardless of family income. It is important to remember that the eligibility restrictions and prohibitions apply only to the applicant's immigration status, not other family members. For example, a child who is a U.S. citizen may have parents who are undocumented. The child in this circumstance can be eligible for health coverage, if all other requirements are met, without regard to parents' status.

If an immigrant alleges to be in a qualified immigrant status as defined in the previous sections, but is unable to present documentation, the Local Office is to advise him in writing of his obligation to contact the INS to obtain the documentation if not obtainable through using SAVE. If the verification cannot be obtained through SAVE and the applicant does not provide documentation from the INS, he is eligible only for emergency Medicaid coverage.

Certain visitors and non-immigrants, as described below, may be eligible for emergency Medicaid coverage. (f4) They must meet all eligibility requirements except the factor of citizenship/immigration status and Social Security numbers. Note, that these individuals may not meet the State residency requirement and would not be eligible for health coverage.

Visitors, tourists, foreign students, temporary workers, crewmen on shore leave, diplomats, members of foreign information media, exchange visitors, and so forth, who are lawfully admitted for specific periods of time and with no intention of establishing a permanent residence in the U.S.

These non-citizens would have the following types of documentation:

- I-94, Arrival - Departure Record;
- I-185, Canadian Border Crossing Card;
- SW-434, Mexican Border Visitor's Permit;
- I-186, Non-Resident Alien Mexican Boarder Crossing Card;
- I-95A, Crewman's Landing Permit; or
- I-184, Crewman's Landing Permit and Identification Card.

Under no circumstances, are undocumented immigrants applying for traditional Medicaid or Hoosier Healthwise to be reported by the Division of Family and Children to the Immigration and Naturalization Service. This also applies to family members of such applicants.

2402.20.50.05 Definition Of Emergency Services (MED)

This section applies to all categories except MA 10. The classifications of immigrants who qualify for emergency services only (see Section 2402.20.50) are not eligible for MA 10.

Emergency services are defined as services required for a medical condition (including labor and delivery) manifesting itself by acute symptoms (including severe pain) serious enough that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

A non-citizen eligible only for emergency services will receive a Hoosier Health Card. When providers use their Eligibility Verification System, the enrollee's limited coverage will be reported. Providers are alerted to this coverage limitation, and have information on the definition of an emergency and claims payment restrictions. Local Offices are not expected to address claims payment difficulties or disputes concerning the emergency nature of an illness. Providers are to be referred to Provider Assistance at the Fiscal Contractor.

2402.20.55 Systematic Alien Verification For Entitlements (SAVE)

In addition to obtaining documentation from the AG (as discussed in Section 2402.20.05), the Local Office is required to verify each alien's immigration status with Systematic Alien Verification for Entitlements (SAVE). SAVE was established by the Immigration and Naturalization Service (INS) to implement a provision of the Immigration Reform and Control Act of 1986 which mandated direct verification of alien immigration status with INS. INS has undergone a name change to Citizenship and Immigration Services (CIS) under the Department of Homeland Security.

NOTE: SAVE procedures are not to be initiated for individuals who declare that they are U.S. citizens by birth or naturalization. (Verification requirements for citizens are discussed in Sections 2402.15.00 and 2402.15.05.)

All alien applicants must present original documentation of alien registration or another form of documentation which is reasonable evidence of their status. Aliens without

documentation should be referred to the local CIS office prior to using SAVE procedures. Most alien applicants will present documentation that contains an Alien Registration Number (A-number). The seven or nine digit number preceded by the letter "A" is unique for each individual.

The Local Office requests SAVE verification by utilizing the Policy Answer Line (PAL). A SAVE request must include the case name and number and each alien case member's:

name;
alien registration number; and
program choices.

The name of the person making the request should also be included.

Upon receipt of a SAVE request, Central Office staff accesses the SAVE database for the following information:

Verification number (this number must be documented in the case record;

Last name;

First name;

Date of birth (mm/dd/yy);

Employment eligibility statement;

Immigration status;

Country of birth;

SSN if known;

Alternate ID number, if known; and

Date of entry (mm/dd/yy).

The data is then transmitted to the Local Office from the Policy Answer Line (PAL).

Through access of the SAVE database by Central Office staff, we may receive a response from SAVE indicating “Additional Verification Required”. If this occurs, Central Office staff will respond to the Local Office with a request for further information that will include:

I-94 Number

ICES Case Number

Document Type (Examples of which could include:

I-327 - Re-entry Permit
I-551 - Permanent Resident Card
I-571 - Refugee Travel Document
I-688 - Temporary Resident Card
I-688A - Employment Authorization Card
I-688B - Employment Authorization Document
I-766 - Employment Authorization Card
I-94 - Arrival/Departure Record Card
Other - use document description
Unexpired Foreign Passport

Document Date

Document Expiration Date

Date of Birth

Upon receipt of this additional information, Central Office staff will submit the information to SAVE. This secondary request to SAVE takes approximately 3-7 business days for CIS to research. The response from SAVE will either note the requested alien status or will request the need for a Documentation Verification Request (Form G-845) to be sent.

The G-845 is to be sent to CIS with a copy of the original documentation provided by the AG. This material is sent to the following address:

U.S. Citizenship and Immigration Service
2221 S. Clark Street
Arlington Va. 22205
ATTN: Immigration Status Verification Unit

NOTE: If the original alien documentation presented by the AG does not contain an alien registration number, the Local Office must contact CIS as indicated above. Central Office staff cannot access the SAVE database without the alien registration number.

When the Form G-845 has been returned to the Local Office, any necessary changes to the Alien/Refugee Information screen AEICZ should be made.

NOTE: Normal case processing is to continue once the AG has provided the initial verification of alien status. Benefits are not to be delayed, denied, or reduced on the basis of pending SAVE verifications.

2403.00.00 NATIVE AMERICANS/ALASKAN INDIANS (MA 10)

Children who are Native Americans or Alaskan Indians (NA/AI) are exempt from the cost-sharing requirements of the

Children's Health Plan, Package C of Hoosier Healthwise.(f4a) A child must be a member of a federally recognized tribe in order to receive the exemption. Any individual claiming Native American racial-ethnic heritage for a child applicant or recipient should be asked whether the child is a member of a federally recognized tribe. If so, membership must be verified in order for the exemption to apply. Verification is accomplished by viewing the I.D. card or tribal letter issued to each enrolled member. The I.D. card or letter should specifically state that the child is an enrolled member and that the tribe is recognized by the federal government. If the documentation has been lost, the parent/caretaker may provide the telephone number of the tribal administrative office so that the child's membership can be verified. If the parent declares potential membership but the child has never been formally enrolled, he/she is not eligible for the cost sharing exemption.

The only tribe currently recognized in Indiana is the Pokagon Band of the Potawatomi Indians. The tribe's I.D. card features a red tribal emblem (an eagle on a branch) and an enrollment number, and shows the child as a member of the Pokagon Band of the Potawatomi Tribe as certified by the tribal chairman. If the parent indicates that the child is an enrolled member, but written documentation has been lost or stolen, enrollment may be verified by calling the Pokagon Band Administrative Offices at 1-888-782-1001. Although the Pokagon Band is the only certified tribe in Indiana, it is important to remember that members of federally recognized tribes may be living anywhere. A child who is an enrolled member of any federally recognized tribe is entitled to the exemption, if otherwise eligible for MA 10.

Since these individuals are not to be required to pay a premium or co-payments, it will be necessary to fiat MA 9 eligibility once it has been established that the child qualifies in all other respects for MA 10. The situation must be fully documented on CLRC (Running Record Comments).

2404.00.00 REQUIREMENT TO PROVIDE SOCIAL SECURITY NUMBER

The policy stated in this section does not apply to ADCQ, MA Q, or MA X or to individuals who are eligible for emergency services only under Medicaid.

Each applicant must, as a condition of eligibility, furnish his Social Security Number (SSN).(f6) A verbal statement from the individual or his authorized representative is sufficient to meet this requirement. If the SSN is unknown or has never been obtained, the individual must apply for a SSN through the local Social Security Administration (SSA) office. The procedure to apply for a number is outlined in Section 2404.10.00.

The applicant should be informed that when applying for food stamps providing the Social Security Number (SSN) of each household member is voluntary, however, failure to provide the SSN will result in the denial of food stamps to each individual that does not provide this information.

The caseworker must request that AG members whose income or resources are included in the budget, but who are not participating members of the AG, provide their SSN for purposes of data exchange. These individuals are not required to comply with this request. Refer to Section 3205.00.

If any applicant/recipient shows multiple cards for himself to the Local Office, it is to be reported to the local SSA District Office for investigation. The same procedure applies if it is suspected that multiple SSNs exist.

2404.10.00 COMPLETION OF SOCIAL SECURITY NUMBER REFERRAL

The policy stated in this section does not apply to ADCQ, MA Q, MA X or undocumented immigrants or visiting non-citizens.

An applicant/recipient who does not have an SSN or who cannot remember the SSN, must contact the SSA and apply for a number. An ICES generated Social Security Number Referral must be given to the individual at the time of the initial interview. The caseworker enters a "?" in the verification field on AEIID. The caseworker then enters the print request on the AEWPR screen. The caseworker and applicant/recipient are to sign the form. The original and one copy are given to the applicant/recipient, and the third copy is retained in the case file. When the SSN application has been submitted, the SSA will complete the bottom portion of the Social Security Number Referral and send the original to the Local Office and the copy to the applicant/recipient. The form must be retained in the case file as documentation that the individual has complied with the eligibility requirements, and the appropriate verification code is to be entered on AEIID.

2404.10.05 Social Security Number Referral Follow-Up (C, MED)

The policy stated in this section does not apply to ADCQ, MA Q, MA X, or undocumented immigrants or visiting non-citizens.

If the Social Security Number Referral form is not received by the Local Office within 10 days of the date it was given to the individual, the caseworker must send a follow-up letter to the applicant/recipient, advising him of the responsibility to apply for a SSN. The caseworker must track the initial 10 day period. The letter must advise the

individual to immediately contact the caseworker if he is having difficulty complying with the SSA's request for documentation, or if the individual has received his copy of the Social Security Number Referral form. If the individual does not respond, a final follow-up letter must be sent, allowing him adequate time to comply before the application is denied.

If an individual has fully complied with the SSA's requirements for an SSN application and is otherwise eligible, the Local Office is not to deny assistance, delay granting assistance, or discontinue assistance pending issuance of the SSN. (f7)

2404.15.00 HOSPITAL ENUMERATION

The policy stated in this section does not apply to ADCQ, MA Q, MA X or undocumented immigrants or visiting non-citizens.

The notice provided by hospitals indicating that an individual applied for a SSN is sufficient verification of compliance with eligibility requirements **only** if the notice (SSA-2853) contains the applicant's name and is signed and dated by a hospital representative and includes the title of the representative.

2404.20.00 EXCEPTION TO PROVIDING/APPLYING FOR A SSN (F)

The SSN requirement may be waived for the month of application for individuals in expedited households. These individuals must apply for or provide a SSN prior to the first full month of eligibility unless good cause exists. Refer to Section 2404.20.05)

EXCEPTION: AGs who receive combined benefits will have until the 30th day to provide verification.

Individuals who have good cause as determined by the caseworker for failure to apply for a SSN are eligible for one month in addition to the month of application. For example, if the AG applies on January 15, and is eligible for January, the re-evaluation of good cause begins March 1. Good cause must be evaluated each month in order for the individual to continue to be eligible.

If the AG is unable to provide proof of application for an SSN for a newborn, the SSN requirement will be waived until the next recertification or six months from the month the baby was born, whichever is later. If the AG is unable to provide the newborn's SSN or proof of application by the end of the waiver period, the worker must determine if good cause exists. Refer to Section 2404.20.05.

Categorically eligible AGs are assumed to have fulfilled this requirement. No further verification is required.

2404.20.05 Social Security Number Good Cause Determination (F)

To determine if good cause exists for failure to comply with the requirement to apply for or provide an SSN, the caseworker shall consider information provided by the AG or SSA. Documentary evidence or collateral information indicating that the AG member has applied for a SSN or made every effort to supply information to complete the application is considered good cause for not complying timely with the requirement. Good cause must be determined monthly for the member to participate as a member of the AG.

Good cause does not include delays due to illness, lack of transportation, or temporary absences, because SSA makes provisions for mailing applications in lieu of applying in person. If the AG member can show good cause why an application for a SSN has not been completed in a timely manner (for example, obtaining an out-of-state birth certificate), that person shall be allowed to participate for one month in addition to the month of application.

2404.25.00 REFUSAL TO COMPLY WITH SOCIAL SECURITY NUMBER REQUIREMENT

The policy stated in this section does not apply to ADCQ, MA Q, MA X or undocumented immigrants or visiting non-citizens.

Penalties may be assessed when an individual does not apply for, or provide, a SSN. These penalties are discussed in the following sections.

2404.25.05 Penalties For Social Security Number Non-Compliance (F)

The individual who does not comply with the SSN requirement is an ineligible AG member. He is not counted in the AG size, but a portion of his income and expenses is counted. His resources count in their entirety. This sanction will continue until the person who has failed to comply comes into compliance with the SSN requirement.

2404.25.10 Penalties For SSN Non-Compliance (C, MED)

The policy stated in this section does not apply to ADCQ, MA Q, MA X or undocumented immigrants or visiting non-citizens.

The refusal of an applicant to provide or apply for an SSN results in his ineligibility. (I8) This ineligibility will continue until the person who has failed to comply comes into compliance with the SSN requirement.

When the ineligible individual is a parent or sibling required to be included in the AG, his income and resources must be considered when determining the financial eligibility of the remaining AG members. (f9)

When the ineligible person is the only participating person or dependent child in the AG, the entire AG is ineligible for TANF or MED 2 category as there is no eligible child.

2404.30.00 VERIFICATION OF SOCIAL SECURITY NUMBER

The policy stated in this section does not apply to ADCQ, MA Q, MA X or undocumented or visiting aliens.

ICES completes a data exchange with the SSA for the purpose of verifying SSNs. When a SSN is verified, ICES is automatically updated with "DE" to reflect the verification on screen AEIID.

2404.30.05 Social Security Numbers Not Verified Through Data Exchange

The policy stated in this section does not apply to ADCQ, MA Q, MA X or undocumented immigrants or visiting non-citizens.

If verification does not occur through data exchange, ICES will generate alert number 708, SSA Numident Match DISCRP-DENB. The caseworker must obtain verification of the individual's SSN to ensure the correct number is being submitted for verification. The following documentation is acceptable:

SS card;

correspondence from SSA containing the individual's name and account number (if the number has an A, J, M, or T suffix, this is the SSN);

a Social Security check issued on the individual's own account number;

a Medicare card issued on the individual's own account number (if the number has an A, J, M, or T suffix, this is the SSN); or

a SSA certificate of award which will contain a claim number (if the number has an A, J, M, or T suffix, this is the SSN).

The caseworker must establish that Social Security coverage is provided under the individual's own account number and not someone else's with the individual as a beneficiary.

Once verification is obtained, the caseworker enters a verification code on the DENB screen.

2406.00.00 RESIDENCY

In order to receive assistance, all individuals must be residents of Indiana. Specific program requirements are explained in the following sections.

2406.05.00 RESIDENCY OF HOMELESS INDIVIDUALS

Homeless individuals and residents of public or private nonprofit shelters for the homeless and/or Domestic Violence victims located in Indiana meet Indiana residency requirements. An otherwise eligible individual must not be required to reside in a permanent dwelling or have a fixed mailing address.

2406.10.00 RESIDENCY REQUIREMENTS (F)

Residency requires the intent to reside either permanently or temporarily in the state; however, individuals in the state solely for vacation purposes are not considered residents. (f10)

Residency requirements do not have to be assessed for categorically eligible AGs.

2406.15.00 RESIDENCY REQUIREMENTS (C)

A resident of Indiana is one who is living in Indiana voluntarily with the intention of making a home here and **not** for a temporary purpose. Residence does not depend upon the reason for which the individual entered Indiana, except insofar as it may bear upon whether he is here voluntarily or for a temporary purpose. Under this definition, the child is a resident of the state in which the caretaker relative is a resident. (f11)

Individuals who are receiving assistance from another state while in Indiana are presumed to be residents of that state. Verification of the termination of assistance from that state is needed in order to establish eligibility in Indiana.

An individual visiting relatives in Indiana would not be considered to be an Indiana resident. However, migrants and itinerant workers moving from state to state for employment purposes, and homeless individuals, meet the residency requirement and may receive assistance if they are otherwise eligible.

Additionally, residents of Indiana who leave the state for shelter from Domestic Violence, are to be considered Indiana residents unless they specifically state that they have no intention of returning to Indiana.

2406.20.00 RESIDENCY REQUIREMENTS (MED)

Federal regulations regarding residency specifically prohibit states from denying MA to any individual on the grounds that he has not resided in the state for a specific period of time, or did not establish residence in the state prior to entering an institution. However, workers must make sure that individuals are not approved who are not Indiana residents according to the eligibility rules. (f12)

In determining whether or not an individual meets the residency requirement, "capability of indicating intent" is a factor. An individual is considered incapable of indicating intent if he:

Has an I.Q. of 49 or less, or a mental age of seven or less;

is judged legally incompetent; or

is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist, or other person licensed by the state in the field of mental retardation.

2406.20.05 Residency Of Non-Institutionalized Individuals (MED)

Individuals under age 21:

The state of residence is the state where the individual is currently living.

If the individual is emancipated from his parents or married, and is capable of indicating intent, the state of residence is the state where he is living with the intention to live there permanently or indefinitely.

Individuals age 21 and over:

The state of residence is the state where the individual is:

Living with the intention to remain there permanently or indefinitely;

living and where he entered with a job commitment or seeking employment (whether or not currently employed); or

living, if incapable of indicating intent.

2406.20.10 Residency Of Institutionalized Individuals (MED)

Individuals under age 21:

For any institutionalized individual who is neither married nor emancipated, the state of residence is:

The parents' state of residence at the time of the individual's placement in the institution (if a legal guardian has been appointed and parental rights are terminated, the guardian's state of residence is used instead of the parents');

the current state of residence of the parent who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's); or

the state of residence of the person who filed the application if the individual has been abandoned by his parents, does not have a legal guardian, and is institutionalized in that state.

If the individual is emancipated from his parents or married, and is capable of indicating intent, the state of residence is the state where he is living with the intention to live there permanently or indefinitely.

Individuals age 21 and over:

For an institutionalized individual who is capable of indicating intent, the state of residence is the state where he is living with the intention to remain there permanently or indefinitely.

For an institutionalized individual who became incapable of indicating intent at or after age 21, the state of residence is the state in which the individual is physically present, except when another state makes a placement. (Refer to Section 2406.20.10.05 regarding out-of-state placement.)

For any institutionalized individual who became incapable of indicating intent before age 21, the state of residence is:

That of the parent applying for Medicaid on the individual's behalf, if the parent lives in a separate state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the legal guardian is used instead of the parent);

the parent's state of residence at the time of the individual's placement in the institution (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's);

the current state of residence of the parent who files the application, if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's); or

the state of residence of the person who files the application, if the individual has been abandoned by his parents, does not have a legal guardian, and is institutionalized in that state.

The applicant's intent to remain in Indiana must always be determined. If the applicant is capable of indicating intent according to the criteria in Section 2406.20.00, the worker must ask the applicant if he plans to remain in Indiana permanently or indefinitely. An applicant who intends to return to the state of origin whenever a bed becomes available, or one who will return to the other state after a temporary institutionalization, is not to be considered an Indiana resident.

Be alert to situations in which the family searched for a bed in the other state before resorting to placement in Indiana and when the applicant is on a waiting list for a facility in the other state.

During the interview with the applicant's representative, the worker will need to ask the reason(s) the applicant was placed in Indiana instead of in a facility in the state where the person had resided prior to the placement. In many cases the family member's clear intent may be to move the applicant back to the other state as soon as a bed becomes available. However, it is the applicant's intent that must be determined. If the applicant is incapable of indicating intent, he is considered an Indiana resident unless the other state arranged the placement. Section 2406.20.10.05 explains what constitutes placement by a state.

2406.20.10.05 Out-Of-State Placement In An Institution (MED)

The state arranging or actually making a placement is considered as the individual's state of residence. This includes any agency of the state or entity recognized under state law as being under contract with the state for such purposes.

Any action beyond providing information to the individual and his family would constitute arranging or making a state placement. The following actions do not constitute state placement:

Providing basic information to individuals about another state's Medicaid program, and information about the availability of health care services and facilities in another state; or

assisting an individual in locating an institution in another state, provided the individual is capable of indicating intent and independently decides to move.

When a state has made a placement of a competent individual and such individual leaves that facility, the individual's state of residence is where he is physically located.

When a placement is initiated by a state because the state lacks a sufficient number of appropriate facilities to provide services to its residents, the state making the placement is the individual's state of residence.

2406.25.00 TEMPORARY ABSENCE FROM INDIANA

Residence is retained until abandoned. Temporary absence from Indiana, with subsequent returns to the state or intent to return when the purpose of the absence has been accomplished, does not interrupt continuity of residence. (f13) See also Temporary Absence for TANF and Food Stamp households in Section 3205.05.10. Assistance cannot be discontinued when an individual leaves the state temporarily and no other state recognizes him as a resident for assistance purposes during the absence. (f14)

2406.30.00 PERMANENT ABSENCE FROM INDIANA

If the recipient leaves Indiana with the intent of establishing residence in another state, assistance is to be discontinued.

2406.35.00 RESIDENCY VERIFICATION

Residency must be verified and documented. Documentation that provides a name and address, such as the following, may be used to verify residency:

driver's license;

school records;

other forms of I.D;

employment records;

church records;

rent/mortgage receipts and/or utility bills;

local postal record; or

written statement from a third party

In the event no written documentation is available, a collateral contact such as the following may be used:

landlord;
neighbor;
utility company;
school;
shelter manager; or
employer

2407.00.00 QUESTIONABLE ADDRESS (F)

When the caseworker becomes aware that the address most recently reported by the AG may not be its residence, resolution of this discrepancy is required. The caseworker will become aware of these discrepancies through such circumstances as:

His own observations; or

the AG's mail is returned to the Local Office with notations indicating that the addressee does not reside at that location.

The fact that the AG is not residing at the last reported address does **not** render the AG ineligible for assistance, but it is an indication that further investigation is required.

The steps required to resolve this discrepancy are described below:

Send the AG a pending checklist asking for proof of residency. Send this notice to the last known address in a forwardable envelope. Send this notice within 10 days of the date the discrepancy is discovered. Allow the AG 10 days to respond. The caseworker must track the 10 day period manually.

If there is no response and the pending checklist is not returned to the Local Office, send a notice of eligibility to the last known address in a forwardable envelope, notifying the AG that benefits will be cancelled due to "failure to verify information necessary to determine eligibility such as identity, assistance group composition, resources and/or income". The termination is effective the first of the month after the date advance (13-day) notice is sent.

If the pending checklist is returned by the Post Office, the caseworker should check the case file to be sure that the form was sent to the correct address. If the address was correct, and the pending checklist is returned indicating no known forwarding address, no further action is necessary. If the address was incorrect, and the caseworker still has reason to believe the AG does not live at the reported address, repeat the above procedures.

2408.00.00 IDENTITY (F)

The identity of the individual making application must be established. If an authorized representative applies on behalf of a household, the identity of both the authorized representative and the individual making application must be established.

2408.05.00 VERIFICATION OF IDENTITY (F)

Identity may be verified by using any type of readily available documentation or, if this is unavailable, through a collateral contact. Examples of acceptable documentation include, but are not limited to, the following:

driver's license;
work or school I.D.;
voter registration card;
wage stubs;
birth certificate; and
I.D. for health benefits or for any assistance or social services program

2410.00.00 AGE

All assistance programs have age related requirements. Age may be either a requirement for eligibility, a requirement for special budget considerations, or a requirement for an exemption from employment and training activities.

2410.05.00 DEFINITION OF A CHILD (C, MED 2, MED 3)

To be considered a child for program eligibility purposes, an individual must be under the age of 18 and unmarried, divorced or separated. A married minor is, therefore, not treated as a child in the TANF eligibility determination. He is excluded from the TANF AG unless he is the parent/caretaker relative of a dependent child.

2410.05.05 Age Requirements (MED 2)

The age requirements for the categories of assistance under MED 2 vary. The age requirements for each category are listed below.

There are no age requirements for the following categories:

MA M - Full Range MA for Pregnant Women; and

MA Q - MA for Refugees who are ineligible for Cash Assistance

Medical Assistance is available to children under age 18 in the following categories:

MA C - low income families (a parent/caretaker would not be subject to an age requirement);

MA F - Transitional MA (a parent/caretaker would not be subject to an age requirement);

MA 3 - MA for wards; and

MA U - MA for SSI recipients (a parent/caretaker would not be subject to an age requirement)

Medical Assistance is available to children under age 21 in the following category:

MA O - MA for Children in Psychiatric Hospitals.

Medical Assistance is available for dependent children age 18 - 21 in the following category:

MA T - MA for 18, 19, and 20 Year Olds.

2410.05.10 Age Requirements (MED 3)

The age requirements for the categories under MED 3 vary, and are listed below.

There is no age requirement for the pregnancy coverage categories of MA N and MA E.

The age requirement for MA X (Newborns) and MA Y is birth through one year old.

The age requirement for MA Z is that a child be at least age one, but not yet age six.

The age requirement for MA 2 is that a child be at least age six but not yet age nineteen.

The age requirement for MA 9 is that the child be at least age one, but not yet nineteen.

The age requirement for MA 10 is birth through age eighteen.

The age requirement for MA 14 is that the individual be 18, 19, or 20 years of age.

2410.05.20 Child Attains Age Limit (C, MED 2, 3)

When a child attains the age limit on the first day of the month, he is ineligible for that month.

When a child attains the age limit on a date other than the first of the month, the child is eligible for the entire month. Ineligibility will begin the first day of the following month.

If there is more than one child in the AG, the child attaining the age limit is to be removed from the AG.

2410.05.25 Verification Of Age (C, MED 2, 3)

Acceptable sources of verification of age include, but are not limited to, the following:

Birth certificate or health department records; or other credible sources, including:

- hospital records;
- physician's records;
- Bureau of Vital Statistics;
- baptismal, confirmation, or other church records;
- passport;
- naturalization papers;
- immigration papers;
- alien registration card;
- court records, including adoption records, in which the child's age has been noted;

- records of social agencies (including the Local Office);

- insurance company records; and

- school records

2410.10.00 AGE OF ELDERLY INDIVIDUALS (F)

Individuals who are or will be 60 in the month of application are considered "elderly". These individuals may have medical expenses deducted and are eligible for special budget considerations (uncapped shelter, not subject to gross income limits).

2410.10.05 Verification Of Age For The Elderly (F)

Verification of age is not required for Food Stamps unless it is questionable.

2410.15.00 AGE REQUIREMENT (MED 1)

There is no age requirement for MA B and MA D.

To be eligible for Medicaid under the MA A category, an applicant must be 65 years of age or older. (f15) An otherwise eligible individual who turns age 65 during a month is eligible for Medicaid under the aged category for that entire month. An applicant must meet the disability or blind requirements in the month preceding the month in which he becomes age 65. Refer to Section 2412.25.00.

To be eligible for M.E.D. Works (MADW and MADI) an individual must be at least 16 years of age but less than 65 years of age. (f15a)

2412.00.00 BLINDNESS OR DISABILITY (MED 1)

The policy stated in this section only applies to the MA B, MA D, MADW, MADI, and MA R categories of assistance.

During the interview it is important to ask each Medicaid applicant if he is blind and/or disabled. (This question first comes up on AEIIM.) Then, when completing AEIDP, the client's responses to each question, "Are you blind" and "Are you disabled" must be entered. If the individual responds that he is blind and disabled, it is necessary that a "yes" response be entered for both questions. This will enable the Medicaid Medical Review Team (MMRT) to enter their decisions on AEOMD regarding both blindness and disability, if there is sufficient medical documentation to do so.

In order to qualify for assistance as a blind or disabled individual, specific medical criteria must be met. These requirements are discussed in the following sections.

2412.05.00 DEFINITION OF BLINDNESS (MED 1)

The policy stated in this section only applies to the MA B and MA R categories of assistance.

The visual requirement must be met by an applicant for MA under the blind category. The requirement is:

> An individual is considered blind if he has central visual acuity of 20/200 or less in the better eye with correction or a field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends an angular distance of no greater than 20 degrees. (f16)

2412.10.00 VERIFICATION OF THE VISUAL REQUIREMENT (MED 1)

The policy stated in this section only applies to the MA B and MA R categories of assistance.

If it appears that all other requirements are met, the procedures outlined below for verification of blindness are to be followed.

The visual requirement is met without further substantiation on a new application or reapplication when:

> Both eyes are missing; (f17) or
>
> the applicant is receiving Supplemental Security Income (SSI) benefits as a "blind individual", "blind child", or "blind spouse". (f18) This is verifiable by the State Data Exchange (SDX). BI, BC, or BS will be indicated under the category column on the SDX.

If the applicant does not meet either of the criteria in the preceding paragraph, he will be required to have an eye examination by an ophthalmologist or optometrist (f19) licensed in the State of Indiana. (f20) The requirement to have an eye examination is applicable even for the applicant who objects to such on religious grounds.(f21) The report must be based on an examination given not more than six months prior to the date of the eye examiner's report. (f22)

An applicant required to have an eye examination must schedule one as soon as possible and notify the Local Office of the doctor's name and the date of the appointment.

The findings of the eye doctor must be submitted on Form 45, Physician's/ Optometrist's Report on Eye Examination. The caseworker is to send the eye report to the doctor, or the applicant, if able to do so, may take the forms to the doctor on the date of the appointment. The caseworker should follow up to be sure that the doctor received the forms. If the doctor prefers, he may submit a letter containing the same information as the Form 45. After completing and signing the eye report, the eye doctor is to forward the original and one copy to the Local Office. The caseworker is responsible for carefully reviewing the eye report to ensure that all items are completed and the form is signed and dated by the doctor. The most legible copy of the eye report is to be forwarded to the Medical Review Team (MRT) at the Central Office for the decision regarding visual eligibility.

The date the eye report is sent to the MRT is to be entered on screen AEIDP.

2412.15.00 PAYMENT FOR EYE EXAMINATION (MED 1)

The policy stated in this section only applies to the MA B and MA R categories of assistance.

The maximum payment for an eye examination necessary to establish initial or continuing eligibility for MA is $29. (f23) The maximum payment for completion of an eye report based on a previous examination for which the doctor has already been paid is $10. (f24)

Form 175, Claim for Services Furnished, is to be attached to the eye report when sent to the doctor, or given to the applicant. The eye doctor is to be instructed to complete and sign the claim form and return it with the eye report to the Local Office. The Local Office is responsible for reviewing the form to ensure that all items are completed and that the provider, applicant, and County Director (or his designee) have signed it. No entry is to be made in the space "Total Amount To Be Paid".

Both the claim form and the eye report should be submitted at the same time to the Central Office. However, Local Offices are not to withhold submission of the eye report pending receipt of Form 175 from the doctor.

Processing of the claim for payment will take approximately four to six weeks.

2412.15.05 Eye Examination Requirement For Reapplications (MED 1)

The policy stated in this section only applies to the MA B and MA R categories of assistance.

An individual who reapplies for MA and who does not meet either of the blindness criteria explained in Section 2412.04.00 may need to have another examination. The guidelines enumerated below are to be followed:

The applicant who had been denied MA, or the recipient whose MA had been discontinued because of failure to meet the visual requirement must have a new examination, and a new eye report must be submitted to the MRT.

If the re-examination date previously established by the MRT has already passed, a new eye examination is required and a current eye report is to be submitted to the MRT.

If the re-examination date previously established by the MRT is in the future, the visual requirement is met for initial eligibility. A re-examination will be required by the previously established date as a condition of continuing eligibility.

If eye examinations have been waived by the MRT, the visual requirement is met and a re-examination of eyesight is not required. (f25)

If the date previously established by the MRT for a re-examination of eyesight is in the future, or eye examinations have been waived by the supervising ophthalmologist, but the Local Office is aware that the applicant underwent eye surgery since the last eye examination, a current eye report is to be submitted to the MRT.

2412.15.10 Inability To Obtain Eye Report (MED 1)

The policy stated in this section only applies to the MA B and MA R categories of assistance.

In no instance is an application to be denied solely because the eye doctor did not return Form 45 to the Local Office, if the applicant is still interested in pursuing his application. As it is the joint responsibility of the applicant and the caseworker to make every effort to obtain visual information, caseworkers must monitor a pending application closely for receipt of the visual information in accordance with the following guidelines:

If the visual information is not received within 20 days from the date of application, the caseworker should check the notice history (CNHS) to make sure the "Initial Letter to Blind Applicant" has been sent to the applicant to remind him that determination of eligibility cannot be made without the necessary visual information. CM08 is the code on CNHS for the 20 day initial letter.

If the applicant contacts the local office after receiving the initial letter, the caseworker should advise him to personally contact the doctor. The caseworker should also immediately contact the doctor by letter or telephone.

If the visual information has not been received within 30 days from the date of application, the caseworker should check CNHS to ensure that the "Follow-up Letter to Blind Applicant" has been sent to the applicant. CM09 is the code on CNHS for the 30 day follow-up letter.

If the applicant responds within the time period specified in the follow-up letter, the caseworker must:

Personally contact the doctor or, as a last resort

refer the applicant to another eye doctor.

If the applicant does not respond to the follow-up letter by the specified date, the application is to be denied.

The date the visual information is received at the local office must be entered on AEIDP. If the date is not entered, ICES will continue to generate and send unnecessary motifs.

If ICES does not properly generate and send the MA B pending notice(s), the caseworker must send a manual notice. Then, the Policy Answer Line (PAL) or the Help Desk should be contacted so the problem can be resolved for future cases.

2412.15.15 Decision Of Medical Review Team (MED 1)

The policy stated in this section only applies to the MA B and MA R categories of assistance.

The MRT will make one of the following decisions regarding the applicant's blindness and enter the decision on AEOMD:

The applicant meets the definition of blindness and further re-examinations of eyesight are waived;

The applicant meets the definition of blindness and a re-examination of eyesight is needed at a future specified date;

The applicant does not meet the definition of blindness; or

Additional visual information is required in order to make a decision as to whether the applicant meets the definition of blindness.

If additional medical information is needed from the eye doctor due to omissions or inconsistencies on the eye report, the caseworker will be responsible for securing the requested information directly from the doctor. If a consultative examination is needed to clarify diagnosis, the caseworker is responsible for arranging for the examination, securing the report, and submitting it to the MRT.

2412.15.20 Required Re-Examination of Eyesight (MED 1)

The policy stated in this section only applies to the MA B and MA R categories of assistance.

The applicant whose vision might be expected to improve will be required to have a re-examination of eyesight as a condition of continuing MA eligibility.

For recipients who initially met the visual requirement because of receiving SSI on the basis of blindness, the caseworker must verify at each redetermination that the recipient continues to receive such benefits. If, for any reason, the recipient's SSI eligibility has been terminated, he must have an eye examination and an eye report must be submitted to the MRT.

If the caseworker questions the continued eligibility of a recipient with regard to the visual requirement, arrangements are to be made for the recipient to have an eye examination. A letter of explanation is to be attached to the eye report and submitted to the MRT.

2412.20.00 TREATMENT FOR RESTORATION OF EYESIGHT (MED 1)

The policy stated in this section only applies to the MA B and MA R categories of assistance.

A blind recipient is required to cooperate in any treatment plan recommended by the examining ophthalmologist and approved for payment by Medicaid which may fully or partially restore his eyesight.(f26)

A recipient cannot be required to undergo any treatment if good cause for refusing exists. "Good cause" includes, but is not necessarily limited to:

The treatment is contrary to his religious beliefs;

previous surgery of the same type recommended was unsuccessful; or

the recommended treatment is very risky because of its magnitude or unusual nature. (f27)

If the blind person refuses the recommended treatment without good cause, the caseworker is to report this fact and the reason(s) for his refusal to the MRT.

The decision to discontinue MA due to the refusal of recommended treatment will be made by the MRT and entered on AEOMD.

2412.25.00 DEFINITION OF DISABILITY (MED 1)

The policy stated in this section applies to the MA D, MADW, MADI and MA R categories of assistance.

In order to qualify under the regular Disability category, MA D, an individual must meet the disability requirement, which is more restrictive than that of the SSI program. The definition in State law is as follows:

An individual meets the disability definition if he or she has one of the following:

A physical or mental impairment, disease, or loss that is verifiable by a physician licensed under IC 25-22.5, that appears reasonably certain to result in death or to last for a continuous period of at least 12 months without significant improvement, and that substantially impairs the individuals ability to perform labor or services or to engage in a useful occupation; or

A mental impairment, disease, or loss that is diagnosed by a physician licensed under IC 15-22.5 or a health services provider in psychology licensed under IC 25-33-1, and verifiable by a physician licensed under IC 25-22.5 or a psychologist licensed under IC 25-33, and that appears reasonably certain to last for a continuous period of at least 12 months without significant improvement, and that substantially impairs the individual’s ability to perform labor or services or to engage in a useful occupation.

> Employment in a sheltered workshop or under an approved vocational rehabilitation plan is not considered a useful occupation. The determination of medical disability shall be made without reference to the individual's ability to pay for treatment. (f27a)

An individual can qualify for the basic category of M.E.D. Works, MADW, if he meets the above disability definition except for the fact that he is working. (f28)

The above definition is also applied for MA R eligibility. (However, the medical definition for cash assistance under the RBA Program of Residential Care Assistance is the same as that of the SSI Program.)

A recipient of M.E.D. Works in the basic category, MADW, who becomes ineligible in that category due to medical improvement, can qualify in the medically improved category of M.E.D. Works, MADI, as long as the medical condition has not been resolved, or the person is not completely recovered. (f28a)

2412.30.00 VERIFICATION OF THE DISABILITY REQUIREMENT (MED 1)

The policy stated in this section only applies to the MA D, MADW, and MA R categories of assistance.

If all other eligibility requirements appear to be met, medical and social information must be obtained on all new applications and submitted to the Medical Review Team, Office of Medicaid Policy and Planning, for a decision regarding the disability requirement.

2412.30.05 Medical Evidence (MED 1)

The policy stated in this section only applies to the MA D, MADW, and MA R categories of assistance.

The applicant, who is not currently under the care of a physician, is to be examined by a physician licensed to practice medicine in Indiana or another state. (f29) The requirement to have a medical examination is applicable even for the applicant or, in the case of a child, the guardian or parent, who objects on religious grounds. (f30) For an applicant who has no physical impairment at all, but whose disability is based solely on mental status, an examination is required by a psychiatrist, psychologist, or mental health professional holding HSPP certification.

If the applicant is currently under a doctor's care, a complete examination may not be necessary provided that the medical data submitted is current within three months of the date of application. Medical records from the last 12

months from all applicable medical sources regarding the applicant's physical impairment and, when appropriate, psychological/psychiatric/developmental records are required.

If a current physical examination is needed, the Local Office is to forward the following forms to the examining physician:

Form 251, Authorization for Physical Examination to Determine Disability for Medical Assistance;

Form 251A, Determination of Disability - Medical Information;

Form 175D, Provider Billing Instructions for Completion of Claims for Services Furnished; and

Form 175, Claim for Services Furnished.

The applicant, if able to do so, and agrees to do so, may take the forms to the doctor. Caseworkers should follow up to be sure the doctor received the forms.

The 251A Medical Form is not to be sent to mental health providers.

Information obtained from these sources should be supplied in the practitioner's usual and customary format.

All applicable portions of Form 251A are to be completed by the physician. Copies of other pertinent medical data, such as x-ray and laboratory results, hospitalization records, and so forth, may be attached. The Form 251A must be signed and dated by the examining physician and returned to the Local Office. If the physician prefers not to complete Form 251A, he may submit the medical evidence in letter format, or copies of existing medical records on the individual. Evidence must include:

1. medical history;
2. clinical findings
3. laboratory findings;
4. diagnosis;
5. treatment; and
6. medical assessment.

In addition to current information about the person's condition, a COMPLETE 12 MONTH MEDICAL HISTORY on the individual is needed unless the documented impairment began less than 12 months prior to application. To facilitate a more timely MMRT decision on a case, the caseworker should attempt to obtain copies of all medical records from physicians and/or hospitals indicated by the applicant as

having treated/examined the applicant for his/her documented impairment within the previous 12 months of the date of application. This is of vital importance and the MMRT will be thoroughly reviewing all cases for this documentation. The MMRT will request copies of pertinent medical information in those instances where additional medical information appears to be available, but was not submitted by the county with the application packet. It will save time in the application process if the caseworker could attempt to obtain the needed information and include it with the application packet submitted initially to the MMRT. If the 12-month medical history is requested by the caseworker but not submitted by the provider, the case may be forwarded to the MMRT for processing. However, the caseworker should indicate on the Form 3511 that the information was requested, but not received. Then, the MMRT will not request that the information be supplied. Obtaining copies of the medical history does not replace the need for a completed OMPP Form 251A (or narrative containing the same medical evidence as the form requires) unless the records contain information from the previous 3-month period. The OMPP Form provides information relative to the applicant's condition as evaluated within the past three months.

2412.30.10 Payment For Disability Examinations (MED 1)

The policy stated in this section only applies to the MA D and MA R categories of assistance.

The maximum payment for a disability examination, including completion of the report, is $65. The maximum payment for completion of a report based on a previous examination for which the doctor has already been paid is $10. (f31) Psychological exams/testing are reimbursed at the rate of $80 per hour. (f32) Additional payments may be allowed for x-rays, tests, and so forth, which are necessary to confirm the primary diagnosis if approved by either the MMRT Supervising Physician or by the MMRT Staff Psychiatrist.

The caseworker is to attach OMPP Forms 175 and 175D to OMPP Forms 251 and 251A and then send them to the doctor or give them to the applicant. The physician must be instructed to return both the claim form and OMPP Form 251A (together) to the Local Office, who will forward them to the Medicaid Medical Review Team (MMRT), Office of Medicaid Policy and Planning. The caseworker is responsible for auditing the forms to ensure that all applicable portions are completed, that the Federal Tax Identification number agrees with the Vendor Microfiche (available from the bookkeeper), that services are properly itemized, and that they are signed and dated by the doctor. The space "Total Amount To Be Paid" is to be left blank on OMPP Form 175. Local Offices are not to withhold submission of the OMPP Forms 3511, 251A and 251B to the MMRT pending receipt of the OMPP Form 175 when the

provider is pursuing payment from insurance or other liable third party.

If a doctor chooses not to submit a claim for his services, this should be indicated on OMPP Form 3511, Request for Action.

2412.30.15 Inability To Obtain Physician's Report (MED 1)

The policy stated in this section only applies to the MA D, MADW, and MA R categories of assistance.

Failure to receive medical evidence is not an acceptable reason for denial of an application if the disabled person is still interested in obtaining Medicaid coverage. As it is the joint responsibility of the applicant and the caseworker to make every effort to obtain the medical information, caseworkers must monitor a pending application closely for receipt of the medical information in accordance with the following guidelines:

If the medical information is not received within 25 days from the date of application, the caseworker should check the notice history (CNHS) to make sure the "Initial Letter to the Disabled Applicant" has been sent to the applicant to remind him that determination of eligibility cannot be made without the necessary medical information. CM06 is the code on CNHS for the 25 day initial letter.

If the applicant contacts the local office after receiving the initial letter, the caseworker should advise him to personally contact the doctor. The caseworker should also immediately contact the doctor by letter or telephone.

If the medical information has not been received within 60 days from the date of application, the caseworker should check CNHS to ensure that the "Follow-up Letter to the Disabled Applicant" has been sent to the applicant. CM09 is the code on CNHS for the 60 day follow-up letter.

If the applicant responds within the time period specified in the follow-up letter, the caseworker must:

Personally contact the doctor or, as a last resort,

refer the applicant to another doctor.

If the applicant does not respond to the follow-up letter by the specified date, the application is to be denied.

The date the medical information is received at the local office must be entered on AEIDP. If the date is not entered, ICES will continue to generate and send unnecessary notices.

If ICES does not properly generate and send the MA D pending notice(s), the caseworker must send a manual notice. Then, the Policy Answer Line (PAL) or the Help Desk should be contacted so the problem can be resolved for future cases.

2412.35.00 SOCIAL INFORMATION (MED 1)

The policy stated in this section only applies to the MA D, MADW, and MA R categories of assistance.

The caseworker is to complete Form 251B, Determination of Disability - Social Summary. This social summary must include factual data, such as work history, education, living arrangements, economic status, and other pertinent information which indicates the extent to which the disability interferes with the applicant's ability to function in his social, family, and economic situation.

If applicable, the caseworker must provide available information regarding SSI as follows:

1. date of application, if benefits are pending;

2. date of SSI denial and reason for denial, or approval;

3. whether or not the SSI denial was appealed;

4. whether or not the applicant's condition has changed;

5. whether or not additional evidence has been obtained which was not presented at the time of the SSI determination;

6. date of appeal hearing;

7. results if available; and

8. 1619 status if applicable.

If the applicant is a child, the social summary should accurately reflect the developmental and educational achievements (or lack of same) of the child. If the child is not attending school, a comparison is to be made of the child's development relative to the normal development of a child of his chronological age. If the child is in special education or learning disabled classes, the reason he is in

these classes, the degree of learning delay and what classes are involved (reading, math, and so forth) must be explained.

Information must be thoroughly and objectively recorded on Form 251B and should be based on the caseworker's observation of and interviews with the applicant. Whenever necessary, the caseworker should interview family members and/or other persons familiar with the applicant's capabilities and limitations. Additional information may be obtained from the records of social service agencies, schools, hospitals, or from Local Office records if the applicant is or has been on other assistance programs.

Caseworkers are to complete the social summary during the interview process. Copies of all medical evidence as listed on page 2 under "Treatment History" should be requested at the same time that the caseworker sends the 251A form, if appropriate, to the physician. If the applicant does not have any medical services to list in the "Treatment History Section", caseworkers are to enter "none" in this section. Leaving it blank or entering "N/A" is not sufficient for the MMRT to make their decision. Completion of Form 215B should not wait until Form 251A has been returned. Copies of records already in the possession of the applicant may also be of benefit. Failure to complete Form 251B is not an extenuating circumstance for pending a case beyond the time standard.

Copies, not originals, of the completed Forms 251B, 175, 3511 and 251A, if appropriate, as well as copies of all other obtained medical evidence should be submitted to the Medical Review Team, Office of Medicaid Policy and Planning. Case packet should also include a copy of the IQSSA ICES screen for SSI recipients.

2412.40.00 DISABILITY INFORMATION ON REAPPLICATIONS/CATEGORY CHANGES (MED 1)

The policy stated in this section only applies to the MA D, MADW, and MA R categories of assistance.

The guidelines to follow concerning the submission of medical/social information to the MMRT for individuals who are reapplying for Medicaid and those whose Medicaid category is changing back to a disability category are outlined below.

A. Medicaid Reapplications

- If the most recent MMRT decision for an applicant is disapproval, new medical and social information must be submitted to the MMRT. (Note that the applicant may or may not have last received Medicaid under the MA D category.)

- If an applicant was previously discontinued under MA D, MADW, or MA R, 48 months or more before the date of the reapplication, new medical and social information is required.

- If an applicant last received Medicaid under MA D, MADW, or MA R and was closed for a non disability-related reason 48 months or less prior to the date of the reapplication, new medical information is not required unless a Progress Report as required by the MMRT is due. The Progress Report is required by the due date previously established by the MMRT, but not sooner. Additionally, if an improvement in the applicant's condition is noted, a Progress Report should be submitted immediately; however, if the MMRT had not previously required a Progress Report, Medicaid is to be approved if all other requirements are met pending the MMRT's decision on the Progress Report.

If the disability approval was made by an Administrative Law Judge, Agency Review or court decision in reversing an MMRT decision, the above requirements with regard to the time frames are applicable to that decision.

B. Category Change to MA D, MADW, or MA R

- If 48 months or less have elapsed since the date that the recipient last received Medicaid under MA D, MADW, or MA R, new medical information is not required unless a Progress Report as required by the MMRT is due. The Progress Report is required by the due date previously established by MMRT, but not sooner.

- If more than 48 months have elapsed since the date that the recipient last received Medicaid under MA D, MADW, or MA R, new medical and social information is required.

The above requirements include changes back and forth between QMB/SLMB-also coverage and QMB/SLMB-only coverage. For example:

> John receives full coverage Medicaid as a QMB-also (MA D and MA L). Effective 6/1, MA D is closed due to excess resources and MA L remains open, so his coverage is reduced to QMB-only. In December, John notifies his caseworker that his resources have been depleted and he wants reconsideration for full coverage Medicaid. Because his MA D was closed for a non-disability reason less than 48 months ago, new medical information is not required.

2412.45.00 DECISION OF MEDICAL REVIEW TEAM (MED 1)

The policy stated in this section applies to the MA D, MADW, and MA R categories of assistance.

The Medicaid Medical Review Team, which is comprised of physicians, a psychological nurse and consultants, (f33) will review the medical evidence and the social information and make one of the following decisions:

> The applicant meets the disability requirement; a progress report is not required.
>
> The applicant meets the disability requirement; a progress report is required by a date specified by the MMRT.
>
> The applicant does not meet the disability requirement.
>
> Additional medical evidence or social information is required in order to make a decision as to whether the applicant meets the disability requirement.

The decision of the MMRT is recorded by the MMRT on the AEOMD screen. If a determination is made that the applicant does not meet the disability requirement, the specific reason this requirement is not met is also recorded on the AEOMD screen. This specific reason for disability denial will be included on the applicant's denial notice. The MMRT will also mail a detailed explanation for the denial both to the caseworker and the applicant. This explanation should be used during the appeals process.

If additional medical evidence or social information is required, the caseworker will be notified via the "Request For Additional Information" Form completed by the MMRT. Requested information will also be reflected on the AEOMD ICES screen. The caseworker will be responsible for

securing the requested information and submitting it to the Medicaid Medical Review Team.

2412.50.00 PROGRESS REPORTS (MED 1)

The policy stated in this section only applies to the MA D, MADW, MADI, and MA R categories of assistance.

When an applicant is approved for MA, the caseworker must check the AEOMD screen to see whether or not a progress report is required. The AEOMD screen will specify in the "re-exam due" field the date on which the progress report is due, and an alert will be generated by ICES. Additionally, Progress Reports may be required by Administrative Law Judges (ALJ).

When a Progress Report is required either by the MRT or an ALJ, the caseworker must complete a new Form 251B, Determination of Disability Social Summary, and obtain a current medical evaluation. If the recipient has been examined within the past three months, Form 251A is to be sent to the doctor for completion. If the doctor prefers, he may submit the medical information in narrative format. A statement written on a prescription slip is not adequate medical documentation. If the recipient has not seen a doctor in three months, arrangements are to be made for him to have an examination.

The Form 251B and the required medical information are to be forwarded to the MMRT by the due date specified in the "re-exam due field " on the AEOMD screen. The Form 3511 (Request for Action) must also be included. The MMRT will review the information and update screen AEOMD with their decision on the recipient's continuing disability status. For the recipient who is currently open in MADW, the MMRT will determine if he remains eligible in that category, is eligible under the medically improved category MADI, or if he has medically recovered to the point at which the disability definition is no longer met. If the recipient remains eligible, another Progress Report may be required.

In addition to required Progress Reports, Local Offices must submit a Progress Report whenever it is learned that the recipient's disabling condition has improved.

2412.55.00 TREATMENT FOR RESTORATION OF PHYSICAL/MENTAL HEALTH (MED 1)

The policy stated in this section applies to the MA D, MADW, MADI, and MA R categories of assistance.

A disabled recipient is required to cooperate in any treatment plan recommended by the examining physician and

approved for payment by Medicaid, which may fully or partially restore his physical or mental health. (f34)

A recipient cannot be required to undergo any treatment if good cause for refusing exists. "Good cause" includes, but is not necessary limited to:

The treatment is contrary to his religious beliefs;

Previous surgery of the same type recommended was unsuccessful;

The recommended treatment is very risky because of its magnitude or unusual nature; or

Amputation of a major limb is involved. (f35)

If the recipient refuses the recommended treatment without good cause, the caseworker is to report this fact and the reason(s) for his refusal to the Medical Review Team, Office of Medicaid Policy and Planning.

The decision to discontinue MA due to the refusal of recommended treatment will be made by the MRT and entered on AEOMD.

2414.00.00 SSI STATUS (F, C, MED 1, 2, 3)

In some situations, an individual's benefit status with the Supplemental Security Income (SSI) program has an effect on his non-financial eligibility. The following sections discuss these situations.

2414.05.00 SSI RELATED INELIGIBILITY FOR CASH ASSISTANCE (C)

An individual is ineligible for Cash Assistance for any month in which he receives an SSI benefit. (f36)

When the only dependent child would be eligible for TANF if he were not an SSI recipient, the parent or other caretaker relative may be eligible for TANF as a one person AG.

2414.10.00 SSI 1619 STATUS

Section 1619 of the Social Security Act provides an incentive to the blind or disabled SSI recipient to continue work when his earned income reaches levels that would otherwise jeopardize eligibility. Individuals in 1619(a) status receive reduced SSI benefits, while individuals in 1619(b) status receive no SSI benefits.

A recipient's 1619-SSI status is verified through data exchange. ICES automatically updates an individual's SSI

status on the AEIDC screen and notifies the caseworker of the update through an alert.

2414.10.05 Categorical Eligibility (F)

Any AG in which all AG members are certified as eligible for SSI, TANF or a combination of both are categorically eligible for Food Stamps. Individuals are considered certified for TANF if they are considered part of the AG. Members not receiving a benefit because of the 24-month limit, members with a voluntary quit penalty, and family cap children are considered part of the AG. Members who have a TANF sanction for IMPACT or IV-D non-compliance are not considered part of the AG or part of the TANF AG.

Categorical eligibility still exists for SSI individuals in 1619 status regardless of receipt or non-receipt of SSI payments. However, individuals who are suspended from receiving SSI benefits because of noncompliance with Drug Addiction and/or Alcoholism (DAA) treatment requirements cannot be considered categorically eligible for Food Stamps. Eligibility for suspended cases would be determined without including an SSI amount until the suspension period ended and benefits are resumed. (f142)

2414.10.10 1619 Status Of Medicaid Recipients (MED)

Blind or disabled SSI recipients who are in SSI 1619(a) or 1619(b) status are eligible for continued Medicaid coverage if they were on Medicaid in the month immediately preceding the month in which an individual's 1619 status last began. (f37) The only non-financial requirement that must be met is state residency.

If a progress report is due for a disabled person who has 1619-SSI status, the Medicaid Medical Review Team (MMRT) should be notified of the recipient's 1619 status. If 1619 status is subsequently lost, a progress report must be submitted immediately to the MMRT. If a re-examination of eyesight is required for a blind recipient in 1619 status, notification to the MMRT is unnecessary. However, an eye report is required immediately upon termination of 1619 status.

Refer to Section 3475.00.00 for additional information about Medicaid eligibility for persons in 1619 status.

2414.10.15 1619 Status Of Cash Assistance Recipients (C)

An individual who has 1619(a) status continues to receive an SSI benefit. This individual is ineligible to receive Cash Assistance due to the receipt of SSI.

An individual who has 1619(b) status no longer receives an SSI benefit and is not automatically excluded from membership in the Cash Assistance AG determination. If the individual's 1619(b) status and subsequent inclusion in the AG causes ineligibility for Cash Assistance, this individual must retain Medicaid eligibility.

2415.00.00 CATEGORICAL ELIGIBILITY FOR MEDICAID WAIVERS

In order to be eligible under a Medicaid Home and Community-Based Services waiver, an individual must qualify under one of the specific aid categories that are approved for the waiver. Caseworkers must ensure that waiver applicant/recipients are considered for Medicaid in the proper category. Verification of the specific waiver for which an individual is either applying or already approved, must be obtained from the waiver case manager. The HCSB waivers and their allowable Medicaid categories are as follows:

Autism waiver – Low-income Families (MA C), Aged (MA A), Blind (MA B), Disabled (MA D)

Aged and Disabled waiver – Low-income Families (MA C), Aged (MA A), Blind (MA B), Disabled (MA D)

Developmental Disabilities waiver – Low-income Families (MA C), Aged (MA A), Blind (MA B), Disabled (MA D)

Medically Fragile Children waiver – Blind (MA B), Disabled (MA D)

Support Services waiver – Low-income Families (MA C), Aged (MA A), Blind (MA B), Disabled (MA D)

Traumatic Brain Injury waiver – Low-income Families (MA C), Aged (MA A), Blind (MA B), Disabled (MA D)

Assisted Living waiver – Aged (MA A), Blind (MA B), Disabled (MA D)

Effective September 1, 2002, the M.E.D. Works categories (MADW, MADI) are covered under all of the waivers.

There are various special eligibility provisions that are applicable in certain categories and under certain waivers as explained in Chapter 3400.

2416.00.00 MEDICARE STATUS (MED 4)

Individuals whose status with the federal Medicare program meets certain requirements, and who also meet other eligibility requirements, can qualify for limited Medicaid

coverage. The following four sections specify the categories under which this is possible.

2416.05.00 QUALIFIED MEDICARE BENEFICIARY (MED 4)

The policy in this section applies to the MA L category of assistance.

In order to be eligible as a Qualified Medicare Beneficiary (QMB) an individual must be entitled to Medicare Part A. An individual meets this requirement if he is enrolled in Medicare Part A, or is eligible for enrollment if a monthly Part A premium is paid. Medicare Part A enrollment can be verified by viewing the Medicare card, a TPQY, or by correspondence from the SSA. If there is no Medicare Part A enrollment, those who are eligible for Medicare Part A with a monthly premium can be identified as follows:

1. Usually have only SSI income;
2. are age 65 or over; and
3. have a HIB number ending in M, J3, J4, K3, or K4, and sometimes T.

Also refer to Page VII-2 of the Medicaid Enrollment Manual Buy-In Section.

No other verification of age is required, nor does the disability requirement applicable to the Medical Assistance for the Disabled category apply to individuals eligible as QMB only.

A QMB must also satisfy the citizenship, residency, SSN, and medical assignment requirements explained in the respective sections of this chapter.

Refer to Section 3010.35.05 for QMB income standards and Section 3005.25.00 for QMB resource standards.

QMB coverage is limited to payment of: (f38)

1. The monthly premium for Medicare Part B;

2. the monthly premium for Premium Hospital Insurance under Medicare Part A, for individuals not entitled to free Part A; (These premiums are required of certain persons entitled to hospital insurance benefits only by voluntary enrollment in the premium paying Part A program.); and

3. Medicare Part A and B deductibles and co-insurance.

An individual can be simultaneously eligible under another full coverage category and QMB. (f39) (Refer to Section 3465.05.00)

2416.10.00 QUALIFIED DISABLED AND WORKING INDIVIDUALS (MED 4)

The policy in this section applies to the MA G category of assistance.

Disabled and working individuals who lost, or will lose, Medicare coverage because of their working status, are entitled to enroll in Medicare Part A under the provisions of the Omnibus Budget Reconciliation Act of 1989 (OBRA-89). If they also meet certain other eligibility requirements, they are eligible for the category of assistance entitled Qualified Disabled and Working Individuals (QDW). (f40)

QDW coverage is limited to payment of the monthly premium for Medicare Part A only. These individuals may also enroll in Medicare Part B (if they are enrolled in Part A), but they will always be responsible for paying the Part B premium themselves.

The individuals who contact Local Offices and wish to apply for the QDW category of assistance should be asked to provide a notice from SSA informing them that they will lose their Medicare because of their working status. The affected Medicare beneficiary will receive such a notice in each of the three months prior to discontinuance of Medicare. An individual whose Medicare was previously terminated should provide a notice he has received from SSA, or some other evidence from SSA, that his Medicare was terminated because he was working.

A QDW must also satisfy the citizenship, residency, SSN, and medical assignment requirements explained in the respective sections of this chapter.

Refer to Section 3010.35.15 for QDW income standards and Section 3005.25.00 for QDW resource standards.

An applicant/recipient is not eligible for QDW if he is otherwise eligible for Medicaid. (f41)

2416.15.00 SPECIFIED LOW INCOME MEDICARE BENEFICIARY (MED 4)

The policy in this section applies to the MA J category of assistance.

Persons who are entitled to Medicare Part A may qualify under the Specified Low Income Medicare Beneficiary (SLMB) category. The eligibility requirements are the same as

those for QMB (refer to Section 2416.05.00) except the income standards are higher. (Refer to Section 3010.35.10 for SLMB income standards.) Coverage is limited to payment of the Medicare Part B premium. (f42)

An individual can be simultaneously eligible for SLMB and a full coverage category or can be eligible as "SLMB-only". A recipient entitled as "SLMB-only" will not receive a Medicaid ID card. If the individual's countable income exceeds the QMB standard, eligibility for SLMB will be determined. (Refer to Section 3005.25.00 for SLMB resource standards.)

2416.20.00 QUALIFIED INDIVIDUALS (MED 4)

The policy in this section applies to the MA I and MA K categories of assistance.

Persons who are entitled to Medicare Part A may qualify under the Qualified Individuals categories of assistance, QI-1 and QI-2. An individual eligible under any other Medicaid category cannot be eligible as a QI.

The QI-1 category is designated as MA I in ICES. The non-financial, income, and resource eligibility criteria are the same as for QMB except that the individual's income for the appropriate family size must be between 120% and 135% of the federal poverty level. (Refer to Section 3010.35.20 for QI income standards and 3005.25.00 for QI resource standards.) QI-1 coverage is limited to payment of the Part B Medicare premium.f42a

The QI-2 category is designated as MA K in ICES. The non-financial, income, and resource eligibility criteria are the same as for QMB except that the individual's income for the appropriate family size must be between 135% and 175% of the federal poverty and QI-2 coverage is limited to payment of only a portion of the Medicare Part B premium.f42b

Qualified Individuals will not receive a Hoosier Healthwise card.

2418.00.00 RESERVED

Reserved

2420.00.00 RESIDENCE IN THE HOME OF A SPECIFIED RELATIVE(C, MED 2)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

Within the MED 2 category, the policy stated in this section only applies to MA C, MA F, MA U, and MA T.

An otherwise eligible child must be **living with** a person having a specified degree of relationship, in a place of residence maintained by one or more of such relatives as his own home. (f65) Once this relationship is established, the specified relative will be denoted as the parent or other caretaker relative.

2420.05.00 RELATIONSHIP OF RELATIVE TO CHILD (C, MED 2)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

Within the MED 2 category, the policy stated in this section only applies to MA C, MA F, MA U, and MA T.

The individual with whom the child resides must be related to the child as specified in the following groups:

1. mother;

2. father, legal or biological;

3. any blood relative within the fifth degree of relationship, including, but not limited to, those of half blood, including first cousins, first cousins once removed, nephews, nieces, and individuals of preceding generations as denoted by prefixes of grand, great, great-great, or great-great-great (this group includes the sister, brother, aunt, and uncle of the child);

4. stepfather, stepmother, stepbrother, and stepsister; (The parent of the stepparent does not meet this degree of relationship. There is no blood relationship, nor can this relationship be established through marriage);

5. an individual who legally adopts a child or the child's parent, as well as the natural and other legally adopted children and other relatives of the adoptive parents; and

6. legal spouses of any individuals named in the five (5) above groups, even though the marriage was terminated by death or divorce. (f66)

When the parental rights of a parent are terminated, that parent cannot be a specified relative unless he has another specified relationship to the child. For example, a child could be adopted by his grandparents. The child and his

birth parent would become siblings which is another specified relationship.

A guardian may receive assistance only when such person is a relative listed above and the child lives with that person.

2420.05.05 Verification Of Relationship (C, MED 2)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

Within the MED 2 category, the policy stated in this section only applies to MA C, MA F, MA U, and MA T.

It is the responsibility of the applicant/recipient to assist the caseworker to verify the degree of relationship between a child and a specified relative.

The relationship of a child to a relative listed in the previous section, except for an alleged father, is verified when the caseworker either:

sees the child's birth certificate; or

obtains verification from two of the sources listed below, when the birth certificate is not seen:

- hospital records established at the time of birth (including a hospital issued birth certificate);
- physician's records;
- marriage records;
- court records, including adoption records;
- Social Security Administration records;
- church documents, such as baptismal certificates;
- passport;
- immigration records;
- naturalization records;
- school records;
- records of social agencies (including the Local Office); or
- signed statement from an unrelated reliable person having specific knowledge about the relationship of the child to the specified relative

2420.05.05.05 Definition Of Presumed Biological Father (C, MED 2)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

Within the MED 2 category, the policy stated in this section only applies to MA C, MA F, MA U, and MA T.

Verification of the relationship of a child to an alleged father is contingent upon Indiana law used for establishing paternity.

IC 31-6-6.1-9 states that a man is presumed to be a child's biological father if:

> He and the child's biological mother are or have been married to each other and the child is born during the marriage or within 300 days after the marriage is terminated by death, annulment, or dissolution;
>
> he and the child's biological mother attempted to marry each other by a marriage solemnized in apparent compliance with the law, even though the marriage is void under IC 31-1-1-2 or IC 31-1-2-2, or voidable under IC 31-1-7-6, and the child is born during the attempted marriage or within 300 days after the attempted marriage is terminated by death, annulment, or dissolution; or
>
> after the child's birth, he and the child's biological mother marry, or attempt to marry, each other, by a marriage solemnized in apparent compliance with the law, even though the marriage is void under IC 31-1-1-2 or IC 31-1-2-2, or voidable under IC 31-1-7-6; and he acknowledged his paternity in a writing filed with the registrar of vital statistics of the Indiana Department of Health or with a local Department of Health.

2420.05.05.10 Paternity Acknowledgment (C, MED 2)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

Within the MED 2 category, the policy stated in this section only applies to MA C, MA F, MA U, and MA T.

A man may acknowledge his paternity of a child if, with the consent of the child's mother:

1. He receives the child into his home and openly holds him out as his biological child; **or**

2. he acknowledges his paternity in writing with the registrar of vital statistics of the Indiana Department of Health or with a local Department of Health.

In situations where a presumed biological father exists, but another man acknowledges his paternity as indicated above, the paternity acknowledgment takes precedence until a legal decision establishes otherwise.

When a child is living with a paternal relative, the Local Office must verify the child's relationship to the father in order to establish the specified relationship of the relative.

2420.10.00 THE "LIVING WITH" DEFINITION (C, MED 2)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

Within the MED 2 category, the policy stated in this section only applies to MA C, MA F, MA U, and MA T.

The child must be living with a specified relative (as defined in Section 2420.05.00) in a place of residence maintained as their own home. A home is the family setting maintained or in the process of being established by the parent or relative, as evidenced by assumption and continuation of responsibility for day to day care of the child by the relative with whom the child is living. (f67) A home exists so long as the relative exercises responsibility for the care and control of the child, even though either the child or the relative is temporarily absent from the customary family setting. (f68)

Within this interpretation, the child is considered to be living with his relative even though:

1. He is under the jurisdiction of the court (for example, receiving probation services or protective supervision); or

2. legal custody is held by an agency that does not have physical possession of the child. (f69)

Placement may be made by either state or out-of-state courts or agencies.

The Local Office's primary responsibility is to establish that the applicant is, in fact, exercising primary responsibility for the care and control of the child.

2420.10.05 Verification Of Living With (C, MED 2)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

Within the MED 2 category, the policy stated in this section only applies to MA C, MA F, MA U, and MA T.

The "living with" requirement may be satisfied by the applicant's/recipient's statement, unless discrepant information exists.

If there is a question whether the child is living with his relative, verification may be obtained from other sources based on the individual situation. Such sources include, but are not limited to:

seeing the child in the home;

school records;

child care provider's records;

landlord's statement;

hospital, clinic, or physician's records;

Social Security or other benefit records;

church records;

court support order;

child welfare records; and

signed statement from a reliable individual having personal knowledge of the child living with the specified relative

2420.15.00 TEMPORARY ABSENCE FROM THE HOME (C, MED 2)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

Within the MED 2 category, the policy stated in this section only applies to MA C, MA F, MA U, and MA T.

Absence of the recipient child or parent/caretaker relative from the home for limited periods of time does not affect eligibility, provided that: (f70)

1. The absent member intends to return to the home by the end of the payment month; and

2. the parent/caretaker relative continues to exercise responsibility for the care and control of the child.

2420.20.00 CHILDREN WHO REMAIN HOSPITALIZED AFTER BIRTH (C, MED 2)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

Within the MED 2 category, the policy stated in this section only applies to MA C, MA F, MA U, and MA T.

Children who remain hospitalized following birth in order to receive medical care are not eligible for assistance in the above categories. For newborn coverage see Section 2428.00.00

2420.25.00 UNSUITABLE HOME (C, MED 2)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

Within the MED 2 category, the policy stated in this section only applies to MA C, MA F, MA U, and MA T.

An otherwise eligible child may not have assistance denied or discontinued because the home in which he resides is considered unsuitable due to the neglect, abuse, or exploitation of the child. (f71) The home shall be considered suitable until such time as the court has ruled it unsuitable and, as a result of such action, the child is removed from the home.

2420.30.00 OBTAINING PHYSICAL CUSTODY TO ESTABLISH TANF ELIGIBILITY (C)

The policy stated in this section affects only the ADCU, ADCR and ADCI categories of cash assistance. It applies to all assistance groups whose eligibility is determined under those categories.

When a person applies for TANF, and at the proposed addition of a child to an existing assistance group, the child's current living arrangement (and the reason for it) must be reviewed to determine whether the child is living with the adult for the sole purpose of qualifying for TANF. (f71a)

This eligibility criterion is considered to be met without further investigation when the child is in the physical custody of a parent or other specified relative who also has sole legal custody or when there is sufficient documentation to establish that:

The child resides with a parent and no other parent is known;

The child resides with a non-parent caretaker relative and the only known parent is deceased or cannot be located;

The child resides with a non-parent caretaker relative and both parents are deceased or cannot be located;

The child resides with a non-parent caretaker relative and one parent is deceased and the other parent's whereabouts are unknown; or

The child resides with a non-parent caretaker relative after placement in the relative's home as a result of parental neglect or abuse.

Note: A "known" parent, in this context, is defined as the child's undisputed mother or father as established legally, biologically or informally. When two men claim paternity or have been named as the child's father, there is no "known" father.

If one of the above situations exists, the caseworker is to indicate on ICES that the physical custody criterion is met by coding "N" in the "Attain Custody For TANF" field on the Welfare Reform Requirements Screen (AEIWR).

Further inquiry will be necessary if none of the circumstances listed above apply. The first step involves asking the current caretaker relative why the child is living with her/him and when the living arrangement began. At this point, AEIWR will be coded "Y" for physical custody only if the caretaker states that the child did, in fact, begin living with him or her to obtain or increase TANF.

If the current living arrangement has been in place for three months or more prior to the application for assistance, a presumption can be made that physical custody was not obtained for the purpose of establishing eligibility for TANF. Verification in these circumstances may be limited to documenting the length of time the caretaker relative and the dependent child have been together. Verification can be obtained from another relative, a friend or neighbor having knowledge of the family history, school, medical or religious records or other legitimate sources.

When the child and the specified relative have been living together less than three months the person with whom the child previously lived should be located for corroboration. Once there is sufficient verification that the child does not currently live with the parent or caretaker to acquire benefits, AEIWR can be coded "N" for physical custody. The

reason for the change in physical custody as well as other pertinent information (dates, individuals contacted, etc.) should be entered on Running Record Comments (CLRC) and all correspondence and collateral documents filed in the casefile.

If a non-parent caretaker relative has physical custody of the dependent child and the living arrangement is not long-term, the situations of both absent parents must be addressed as indicated above.

The provision of the TANF benefit is not to be delayed or denied because the child's previous caretaker failed to provide verification or could not be reached. Verification that physical custody was or was not obtained for the purpose of qualifying for TANF also may include (but is not limited to):

A court order addressing physical custody of the child;

Documentation from Child Protective Services indicating that the child has been placed with the current caretaker relative;

A statement from a professional person having knowledge of the family's situation; or

A statement from a friend, neighbor or family member verifying or refuting the current caretaker relative's stated reason for acquiring physical custody.

The physical custody field on AEIWR is coded "Y" only when there is documented evidence that the child lives with the caretaker relative for the purpose of qualifying for TANF. TANF and TANF-related Medicaid will fail for the child. The caretaker relative will also be ineligible for both benefits unless there is another dependent child in the caretaker's assistance group who meets the physical custody requirement and is otherwise TANF eligible. When one child in a TANF assistance group is ineligible while the remaining members qualify, the caseworker must ensure that Medicaid is chosen for the ineligible child on the Choice of Programs Screen (AEICP). If the child meets the eligibility requirements of another Medicaid category, it will be necessary to fiat the coverage since only one individual (and not the entire assistance group) is ineligible for TANF-related Medicaid. A new application is not required in this situation.

2422.00.00 INSTITUTIONAL STATUS

An institution, as defined by federal regulation, is an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor. (f72)

2422.05.00 RESIDENTS OF INSTITUTIONS (F)

Residents of institutions, with certain exceptions, are not eligible to participate in the Food Stamp program. Individuals are considered residents of institutions when the institution provides them with the majority of their meals (50% of three meals or at least two meals a day) as a part of its normal services.

Students who purchase a majority of their meals at one of a school's facilities are considered residents of an institution regardless of whether obtaining meals at a school facility is mandatory or optional. (Refer to Section 3210.15.35 for definition of eligible student.)

Individuals who do not receive their meals from an authorized institution and prepare their own food, or are participating in a delivered meals program or a communal dining program, are eligible for Food Stamps on the factor of residency.

2422.05.05 Exemptions From Institution Provisions (F)

The following individuals residing in group facilities are residing in eligible institutions and are eligible for Food Stamp consideration:

Any narcotics addict or alcoholic who resides at a public or private non-profit facility or treatment center under the supervision of a drug alcohol treatment and rehabilitation program;

residents of federally subsidized housing for the elderly under either Section 202 of the Housing Act of 1959 or Section 236 of the National Housing Act;

certain blind and disabled individuals as defined in Section 3210.10.25 who live in authorized small group living arrangements;

women or women with children temporarily residing in a shelter for battered women and children (such individuals shall be considered individual household AGs for purposes of applying for and participating in the program); and

residents of public or private nonprofit shelters for homeless individuals.

2422.10.00 RESIDENTS OF INSTITUTIONS (MED)

The Medicaid eligibility of an individual who resides in an institution is governed by the type of institution, in addition to the other eligibility factors. A public

institution is an institution that is the responsibility of a municipal, county, state, or federal governmental unit, or over which such a governmental unit exercises administrative control. Examples of institutions include, but are not limited to, jails, state and federal prisons.(f73) However, for Medicaid eligibility purposes, certain facilities are excluded from this definition by federal regulation, and individuals may be eligible for Medicaid while residing in the facilities listed below. (Special eligibility considerations for persons in psychiatric facilities are explained in Section 2422.10.05.)

Nursing facilities providing skilled and/or intermediate levels of care (public or private).

Acute care hospitals (public or private).

Intermediate Care Facilities for the Mentally Retarded/Developmentally Disabled (ICF/MR, or CRF/DD) (public or private).

Public institutions designed to serve no more than 16 persons and which provide services beyond food and shelter, such as social services, help with personal living activities, or training in socialization and life skills. (f74)

Public educational or vocational training institutions such as Indiana Schools for the Blind and Deaf and Silvercrest Developmental Center;

Medicaid certified state institutions, or portions thereof, under the direction of the Indiana Family and Social Services Administration, Division of Mental Health;

A facility with 16 beds or less, providing inpatient psychiatric care (public or private);

Any other type of privately owned group living arrangement such as a foster home or group home.

Residents of all other public institutions are ineligible for traditional Medicaid and all benefit packages of Hoosier Healthwise (f75) unless the individual is in the institution for a temporary period, pending other arrangements appropriate to his needs.(f76) Examples of such public institutions are county homes which do not meet any of the above criteria of excluded facilities, and reformatory or correctional facilities.

2422.10.05 Residents Of Psychiatric Facilities (MED)

Residents of psychiatric facilities (public or private) may be eligible for Medicaid under the conditions specified below.

A psychiatric facility, or institution for mental diseases (IMD) as referred to in federal regulations, is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care to persons with mental diseases, including medical care, nursing care, and related services. (f77)

Individuals residing in an IMD, as defined above, can be eligible for MA, except MA 10-Package C of Hoosier Healthwise if they are:

Age 65 or older; or

under age 21, reside in a Medicaid certified facility, and have an approved Certification of Need, Form 1261A. Refer to Section 2422.10.10.

Additionally, if a recipient is receiving approved inpatient services prior to age 21, coverage continues until services are no longer required or the recipient reaches age 22, whichever comes first. (f78)

2422.10.10 Certification of Need/Inpatient Psychiatric Care (MED)

In order for individuals under the age of 21 to be eligible for Medicaid in a Medicaid certified psychiatric facility, an approved certification of need, the Form 1261A, Certification-Plan of Care for Inpatient Psychiatric Hospital Services, is required. If the Plan of Care is disapproved for an applicant/recipient, the individual is ineligible for Medicaid while residing in the facility. In order for individuals age 65 and older to be eligible for Medicaid reimbursement of inpatient psychiatric services, an approved Form 1261A is required; however, such an individual is eligible for all other Medicaid services while residing in the psychiatric facility.

The facility is responsible for the completion and submission of the Form 1261A to the appropriate reviewing authority. State facilities submit the Form 1261A to the Medical Review Team, Office of Medicaid Policy and Planning; privately owned facilities submit the Form 1261A to the prior authorization unit of the Medicaid fiscal contractor.

Following approval or disapproval of the plan of care, the original of the Form 1261A will be returned to the facility and a copy will be forwarded to the Local Office for retention in the casefile. Copies of the signed Form 1261A

are not to be forwarded to the Medical Review Team by the Local Office.

For individuals under age 21, facilities are instructed to submit the Form 1261A prior to the admission of a Medicaid recipient. Caseworkers are not to initiate case action until a copy of the approved or disapproved Form 1261A is received. If the Form 1261A is approved, an institution budget is to be completed. If the Form 1261A is disapproved, action to suspend Medicaid should be proposed if the recipient remains in the facility; if the recipient leaves the facility, eligibility is to be determined as appropriate, based on the new living arrangement.

For Medicaid applicants, facilities are instructed to submit the Form 1261A within 10 days after the applicant has been determined eligible for Medicaid. Therefore, caseworkers are to complete the application process in the usual manner, using post-eligibility budgeting procedures. If the Form 1261A is approved, no further case action is required. If the Form 1261A is disapproved, action to suspend should be proposed if the recipient remains in the facility. This is done by entering SUSP on AEWAA and authorizing. If the recipient leaves the facility, eligibility is to be determined as appropriate based on the new living arrangement.

2422.10.15 Persons Age 65 And Older/Inpatient Psychiatric Care (MED)

For applicants/recipients age 65 and older who are admitted to Medicaid certified psychiatric facilities, the procedures explained above are applicable except that a disapproved Form 1261A does not render the person ineligible for Medicaid. Disapproval indicated on screen AEIII means that Medicaid will not provide reimbursement to the facility for inpatient psychiatric services. If the recipient remains in the facility, community budgeting is to be used. Refer to Section 2422.10.10.

2424.00.00 LEVEL OF CARE/PREADMISSION SCREENING (MED)

A Medicaid applicant/recipient who enters a nursing facility, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), or Community Residential/Developmentally Disabled (CRF/DD) must first undergo preadmission screening to determine whether the individual requires the level of care provided by a nursing facility or is entitled to reimbursement on his behalf in an ICF/MR or CRF/DD. When completing AEIII, the caseworker will assume preadmission screening/level of care is approved unless there is information to the contrary. The preadmission screening field should be completed by entering "S" - screened, followed by the date that the individual entered the nursing

facility. (The date that the preadmission screening was actually completed may be used, if it is known.) The caseworker may then proceed with the eligibility determination, including authorization if the individual passes eligibility.

In the event that preadmission screening and/or level of care is denied for the individual, the Local Office will receive a Form 450B, Physician's Certification for Long Term Care Services, that indicates a denial. The caseworker should monitor the Forms 450B that are received by the Local Office. When a denial is received, the caseworker should change the preadmission screening field on screen AEIII from "S" to "D" - denied. The individual's eligibility will then be redetermined by ICES without the post-eligibility budget.

2426.00.00 PREGNANCY (MED 2, 3)

Within the MED 2 and MED 3 categories, the policy stated in this section applies only to MA M, MA N, and MA E. (For definition, see Sections 1620.55.00, 1620.60.00 and 1620.70.00).

To qualify for assistance under these categories, the pregnancy must be verified by a licensed health professional.(f79)

Pregnant women may receive assistance under other categories of assistance, if otherwise eligible, without verifying pregnancy.

2426.05.00 VERIFICATION OF PREGNANCY (MED 2, 3)

To qualify for assistance as a pregnant woman, verification of pregnancy must be provided. Acceptable verification is a signed statement from a licensed health professional that includes:

Confirmation of pregnancy; and
the anticipated date of delivery.

If multiple births are expected, this information should also be included as it affects the income standard used in the eligibility determination. The number of expected births (as verified by the physician) is coded onto the Pregnancy Information Screen (AEIPI). This screen appears whenever pregnancy has been indicated on AEIID.

2428.00.00 NEWBORN STATUS (MED)

The policy stated in this section only applies to the MA X category.

A child born to a woman, who is eligible for traditional Indiana Medicaid or Hoosier Healthwise under any benefit package except C (MA 10), on the date the child is born, is deemed automatically eligible for one year as long as the child continues to live with his mother in Indiana. (f80) Refer to Section 2225.10.00 for information about adding an infant born to a mother eligible for MA 10.

Separation due to hospitalization will not affect the child's eligibility under this category unless the mother has legally relinquished control or it has been established that she has abandoned the child.

The determination of the mother's Medicaid eligibility may be completed prior to or after the child's birth. However, if she applies after the child is born; the child is not MA X eligible unless the birth occurred in the month of application or during the 3-month retroactive period. MA X coverage may be initiated based on notification of the child's birth by the parent, hospital, or any party who has the child's interest in mind and can provide the required information. Sufficient information would include the child's name, sex, and date of birth. An application for the child is not required, and the child is not subject to any other eligibility requirements. Coverage will continue for one year unless the baby stops living with the mother or leaves the state.

2430.00.00 WARDS (MED 2)

To determine MA eligibility for a child in wardship status, failure logic (as discussed in Chapter 2200, Continued Case Processing) leads ICES through the Medicaid Hierarchy to determine if the child is eligible under any other category. The Medicaid category of "last resort", MA 3, is limited to children (wards under the age of 18) who fail to meet the requirements of the other categories.

Income and resource requirements are based on those of the Cash assistance categories. (f81) (See Sections 3010.35.10 and 3005.10.00.)

ICES will form MA 3 for a child who fails the other categories if he is:

A child in need of services (CHINS) as defined in IC 31-6-4-3 or IC 31-6-4-3.1;

a child who has been placed in the custody of the Division of Family and Children and for whom parental rights have been terminated (IC 31-6-5-5); or, a child who is in the custody of or under the supervision of the Division of Family and Children by an order of the court, including a child being detained under protective custody pending CHINS adjudication or a delinquent child.

Children who are under "informal adjustment" do not meet the categorical eligibility criteria.

Documentation which establishes categorical eligibility must be retained in the Medicaid case record.

2432.00.00 REQUIREMENT TO FILE FOR OTHER BENEFITS (MED 1, 4)

Individuals must apply for all other benefits for which they may be eligible, as a condition of eligibility unless good cause can be shown for not doing so. (f82) Benefits that must be applied for include, but are not limited to:

Pensions from local, state, or federal government;
Retirement benefits;
Disability;
Social Security benefits;
Veterans' benefits;
Unemployment compensation benefits;
Military benefits;
Railroad retirement benefits;
Workmen's Compensation benefits; and
Health and accident insurance payments.

In some cases, individuals who are already receiving benefits may be eligible for increased benefits due to a change in their circumstances (for example, veterans' benefits). Individuals are required to apply for all increased benefits for which they may potentially qualify. However, they are not required to apply for Social Security benefits at age 62. Individuals may wait until age 65 to apply.

2432.05.00 REQUIREMENTS FOR REFUGEES (C, MED 2)

The policy stated in this section only applies to the ADCQ and MA Q categories of assistance.

Eligibility under the TANF program must be determined for a refugee who applies for Cash Assistance. If the refugee is not eligible for TANF, eligibility is then determined for the Refugee Cash Assistance Program. (f83)

Likewise, a refugee's eligibility for MA is first considered for all categories of assistance other than Refugee Medical Assistance. (f84) ICES automatically determines a refugee's eligibility in this manner to comply with federal regulations. (Refer to Section 1605.20.00)

In addition, the caseworker must refer refugees who are 65 years of age or older, or who are blind or disabled, to the SSA to apply for assistance under the SSI program. Cash Assistance is to be furnished to eligible refugees until eligibility under the SSI program is determined.

2433.00.00 HEALTH INSURANCE COVERAGE CONSIDERATIONS (MA 10)

There are certain limitations to eligibility under Hoosier Healthwise Package C relative to the coverage or possible coverage of the children under other insurance (f84a) as follows:

Access to the State of Indiana Health Insurance Plan:

Children whose parents, caretakers or spouses can cover them under the State of Indiana's health coverage plans offered to State employees are not eligible for MA 10. This prohibition applies even if the State employee has chosen not to cover the child, and regardless of whether or not an open enrollment period is available to the employee at the time of the Hoosier Healthwise application. The prohibition does not apply if it is a non-custodial parent who is the State employee.

To qualify for coverage for a dependent, the State employee must be a full-time employee living with the dependent, and must be the parent, stepparent, foster parent, legal guardian, or spouse of the dependent. This excludes grandparents who do not have legal guardianship of grandchildren in their care. A married dependent may not be covered under a parent's State benefit package, regardless of age.

If the requirements for coverage under the State benefit package appear to be met but the State employee maintains that the child in his or her care cannot be covered, the employee must present or obtain verification from the agency's health plan administrator. The application should pend awaiting this verification.

Coverage by other health insurance:

Children who are covered by comprehensive health insurance (hospital and medical or major medical) are not eligible for MA 10, even if there is a pre-existing condition or specific diagnosis exclusion clause. This differs from the

limitation above as the issue is verified coverage, not merely access. If a child has health insurance, the MA 10 eligibility determination must pend for verification of the insurance benefit types.

Dropping health insurance coverage:

Children whose health insurance coverage has been dropped voluntarily may not receive MA 10 for three months following the month of termination. The Hoosier Healthwise application (Form 2030) asks for information concerning the reason for the termination of coverage. If "could not afford" is indicated as the reason, the insurance is considered to have been terminated voluntarily and the child is subject to the three-month waiting period. Termination of insurance due to loss of employment (even if the loss was due to a voluntary quit) does not affect the child's eligibility for MA 10. If the family lists a reason that is not on the application or the ICES table, and the worker is uncertain as to whether the termination should be considered voluntary, the Policy Answer Line should be contacted.

2434.00.00 ASSIGNMENT OF MEDICAL RIGHTS (MED)

As a condition of eligibility, each Medicaid applicant/recipient must assign to the state all rights to medical support and payments for medical care for himself and any other Medicaid applicant/recipient whose rights he can legally assign. Also, cooperation in identifying and providing information about responsible third parties, including absent parents, as well as cooperation in obtaining third party payments and medical support, is required unless the applicant/recipient establishes good cause. (f85) Screen AEFMM must correctly indicate assignment status of A, M, or I. The absent parent screens, AEIAP, AEIAC and AEICH will come up in the driver flow. The screens must be filled in as completely as possible. Do not fill in the assignment date. Refer to Sections 2434.05.00 and 2434.15.00.)

The assignment provision covers the following (not all-inclusive) with regard to any medical services which are paid or to be paid by Medicaid:

> The liability of any third party for payment of medical care received by the recipient. This includes individuals, programs, or entities (such as trust funds or absent parents);
>
> medical support orders issued by a court or administrative agency; and

all types of medical insurance, including indemnity policies. "Indemnity policy" commonly refers to a policy which makes cash payments to the individual who incurs specified medical expenses, most often involving hospitalization.

Medicare is not covered under the assignment provisions.

The medical assignment becomes effective on the first day of medical assistance coverage. It remains in effect until the state has been reimbursed for all medical services provided to the Medicaid recipient during the period of time he was Medicaid eligible.

2434.05.00 MEDICAL ASSIGNMENT REQUIREMENTS (MED)

The following individuals must assign their medical rights: (f86)

Legally competent Medicaid applicant/recipient age 18 and older;

minor aged parents/caretakers; and

legally competent Medicaid applicant/recipient age 18 and older who can legally assign the medical rights of another applicant/recipient.

Individuals who must be asked to assign medical rights are listed below. The refusal of any of these persons to do so, however, will not result in a penalty:

Legal guardian of a Medicaid applicant/recipient;

nonrecipient parent of an applicant/recipient under age 18; and

director of Local Office when applicant/recipient is a ward (including wards in foster care).

An interested person may **not** assign medical rights as he has no legal authority to do so. If an interested person has signed the application on behalf of a competent individual, the caseworker must obtain the signature of one of the individuals listed above on the medical assignment unless the individual has been given power of attorney to specifically act on behalf of the client in this matter. The cooperation of the interested person should be enlisted to obtain this signature. Refer to Section 2434.10.05.

2434.10.00 MEDICAL SUPPORT COOPERATION REQUIREMENTS (MED)

The applicant/recipient is required to sign the Application for Assistance-Part 2 (CAF) which contains the medical assignment clause and by which he also acknowledges his receipt of the required "Cooperation Notice", which must be given to the applicant (or his parent/guardian).

He is required to cooperate, unless good cause is established, in obtaining medical support and payments for medical care as follows: (f87)

Provide the Local Office with all information regarding existing and future medical insurance coverage;

Advise the Local Office of any existing or future court orders which provide support for medical care;

Advise the Local Office of any legal action taken or intended to be taken against a third party for injuries he has sustained in an accident; (this also applies to any other applicant/recipient for whom he is legally responsible);

Assist in obtaining any support for medical care available to him under any order of a court or administrative agency;

Assist in obtaining any third party payments which may be available; and

Pay to the Central or Local Office any money from any third party which is paid directly to him for medical services which were or will be paid by Medicaid. (This does not apply to payments for medical expenses incurred by spend-down recipients before that month's Medicaid effective date, payments for non-Medicaid covered services, or payments from Medicare.)

2434.10.05 Incompetent Persons' Assignment Of Medical Rights (MED)

The policy stated in this section does not apply to the MA X category of assistance.

If an applicant/recipient is not mentally competent to assign his medical rights and has no legal guardian, his mental incompetency must be entered on screen AEFMM and documented in the case file. The incompetency finding must be documented by the caseworker and consist of:

A statement in Running Record Comments (CLRC) which references to Forms 251A, 450B, or Pre-admission Screening Forms which verify mental incompetency; or

a written statement from the applicant's/recipient's physician verifying mental incompetence. Documentation of this type must be retained in the hard copy file.

2434.10.05.05 Identification Of Medical Resources (MED)

The Local Office must secure information from the applicant and any other knowledgeable source such as a parent, authorized representative or legal guardian on medical resources that are available or were available during the retroactive period to pay for the applicant's medical expenses. Medical resources include, but are not limited to:

health insurance policies carried by the applicant or carried for the applicant by an employer or relative;

government financed health programs, such as:

- Medicare - Parts A and/or B;
- CHAMPUS (Civilian Health and Medical Program of the Uniformed Services);
- CHAMPVA (Civilian Health and Medical Program of the Veterans Administration); and
- Veterans' benefits.

workman's compensation (for employment related accidents); and

automobile insurance (for automobile accidents).

It is crucial that all medical resources be identified so that, if the applicant is determined to be eligible for MA, the Medicaid Fiscal Contractor, when processing provider claims, can seek payment from these resources **before** payment is made by Medicaid.

2434.15.00 THE RIGHT TO CLAIM GOOD CAUSE - MEDICAL ASSIGNMENT (MED)

If an applicant/recipient refuses to cooperate with any of the medical assignment requirements, the Local Office must notify him of his right to request a good cause waiver. If he claims good cause for not cooperating, he must be given a Good Cause Notice. Additionally, a Good Cause Notice must be given to an applicant/recipient who is deciding whether or not to claim good cause.

If the applicant/recipient claims good cause, a copy of the Good Cause Notice must be retained in the case record.

Good cause is defined as any circumstances in which cooperation would result in serious physical or emotional harm to the individual for whom medical support is sought. The evidence needed to substantiate a good cause claim is specified on the Good Cause Notice. The recipient is to submit the evidence to the Local Office within 20 days of the date of the notice. The Local Office must then forward the evidence to the Family Independence Section, along with a cover letter indicating the recipient's name and case number.

When the applicant/recipient has complied with the good cause requirements and furnished supporting evidence and information, the Medicaid case must not be denied, delayed, or discontinued pending a determination of good cause by the Family Independence Section.(f88)

2434.15.05 Medical Assignment Good Cause Determination (MED)

The Central Office will notify the Local Office in writing of the decision on the recipient's good cause claim. The caseworker is to enter the good cause decision into ICES by using the AEFMM screen. If the decision is that good cause does not exist, the Local Office must notify the recipient and give him the opportunity to cooperate. Continued refusal to cooperate will result in the discontinuance of Medicaid except in the case of minor applicants/recipients, who are not penalized for their caretaker's refusal to cooperate.

2434.15.10 Local Office Review Of Good Cause Determination (MED)

The policy stated in this section does not apply to the MA X category of assistance.

At the time of each redetermination, the Local Office must review the good cause claim. If the determination of the existence of good cause was based on a circumstance which has changed so that good cause may no longer exist, the Local Office must notify the Family Independence Section of such change and recommend that the good cause finding be rescinded. (f89)

2434.20.00 PENALTIES FOR NON-COMPLIANCE WITH MEDICAL RIGHTS (MED)

The policy stated in this section does not apply to the MA X category of assistance.

Medicaid must be denied or terminated for any competent adult applicant/recipient who: (f90)

Refuses to assign his own rights or the rights of any other Medicaid applicant/recipient for whom he can legally do so; or

refuses, without good cause, (Section 2434.15.00), to cooperate.

2434.20.05 Circumstances When Penalties Are Not Applied (MED)

The policy stated in this section does not apply to the MA X category of assistance.

Medicaid eligibility must be approved/continued for the applicant/recipient who:

Cannot legally assign his own rights; and
the person legally authorized to assign medical rights and cooperate in obtaining support for medical care, refuses to do so. (f91)

EXAMPLE: A recipient father refuses to assign the rights of his recipient child; the father is not eligible for Medicaid, but the child is.

2435.00.00 HEALTH INSURANCE PREMIUM PAYMENT PROGRAM (MED)

Indiana Medicaid through the Health Insurance Premium Payment (HIPP) Program is required to purchase (wherever available and cost effective) employer-based group health insurance on behalf of covered Medicaid recipients. The enrollment in such insurance plans is a condition of the covered recipients' Medicaid eligibility.

Please refer to the Administrative Letter regarding the Health Insurance Premium Payment Program, dated February 10, 1995, and the Caseworker Training Guide for HIPP on the procedures to follow for this program.

2436.00.00 CHILD SUPPORT PARTICIPATION (C)

Within the C category, the policy stated in this chapter only applies to ADCR, ADCU, and ADCI.

Certain individuals must cooperate with child support enforcement as a condition of eligibility.

The purpose of the Child Support Program is to identify and locate absent parents, establish paternity, and obtain child support. In effect, the Child Support program:

Promotes greater financial responsibility of parents toward their children; and

provides a support collection service to reduce dependency upon public funds.

The caseworker must thoroughly explain to applicants/recipients the IV-D requirements as they relate to eligibility, and the consequences involved if they do not cooperate. The CAF contains an explanation of cooperation, assignment and penalties for non-cooperation. Refer to Section 2436.20.05.

2436.05.00 CHILD SUPPORT ENFORCEMENT REQUIREMENTS (C)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

Child support enforcement activities include the assignment of rights to support and cooperation in obtaining support. These requirements are discussed in the following sections.

2436.05.05 Assignment Of Rights To Support (C)

The policy stated in this section applies only to the ADCR, ADCU, and ADCI categories of assistance.

All applicants/recipients must assign their rights to child and spousal support to the Child Support Bureau (f92) regardless of whether support is currently being paid or whether paternity has been established.

The applicant's signature on the application serves to assign all current and pending support payments due him or any participating member of his AG, and any arrearage that accrues while receiving TANF. (f93) The assignment date is the date of application. The child support collection date becomes effective the first of the month following the month in which the caseworker takes action on the case. For example, if application is made 8/29/94, and the case was acted upon by the caseworker in September, the collection date would be 10/1/94. TANF benefits would be effective 9/1/94. The only individual who may legally assign support rights is the parent/caretaker relative. If an individual other than the parent/caretaker signs the application, a separate assignment of support rights must be obtained from the parent/caretaker. Information is entered on AEIAC.

One of the results of this assignment is that the payment of all child and spousal support to which the AG is entitled, is made to the Division of Family and Children rather than to the TANF recipient. All support payments must be reported and paid to the Child Support Bureau. The Local Office is responsible for the conversion of child support

payments to the Child Support Bureau as soon as possible after eligibility is established.

2436.05.10 Cooperation In Obtaining Support (C)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

Each applicant for or recipient of assistance must be given a cooperation notice and, unless exempt as described in Section 2436.10.05, is required to cooperate in:

Identifying and locating the parent of a child for whom assistance is requested;

establishing the paternity of a child born out of wedlock for whom assistance is requested;

providing complete information required to obtain support;

obtaining support payments for the applicant/recipient and for a child for whom assistance is requested; and

obtaining any other payments or property due the applicant/recipient or the child for whom assistance is requested. (f94)

Cooperation includes the following:

Appearing at the offices of the child support agency as necessary, to provide verbal or written information or documentary evidence known to be possessed (or reasonably obtainable) that is essential to obtaining support;

appearing as a party to or witness at court or other hearings or proceedings;

providing information, or attesting to the lack of information, under penalty of perjury; and

forwarding any support payments received after the assignment has been executed to the designated child support agency. (f95)

2436.05.10.05 Child Support Cooperation Requirements (C)

Information is to be provided about each absent parent whom the applicant names as a parent of the child. This includes any alleged, acknowledged, or legal parent.

When a minor parent is included as the eligible caretaker in the TANF AG, cooperation is required in providing

information about the parent of the minor's child as well as the parent(s) of the minor parent who do not reside with him.

2436.10.00 CHILD SUPPORT COOPERATION EXEMPTIONS (C)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

A parent/caretaker may be exempt from cooperation requirements if certain conditions exist, or if there is good cause for failing to cooperate. These exemptions are discussed in the following sections.

2436.10.05 Automatic Child Support Exemptions (C)

Cases which fall under any of the following categories are automatically exempt from cooperation requirements:

Deprivation is based on the verified death of a parent.

The parent is incapacitated and living in the home.

The absent parent's parental rights have been involuntarily terminated by court order.

The parent/caretaker relative receives TANF based solely upon the only child's receipt of SSI benefits.

The child was adopted by a single parent and is living with that parent.

The parent of the minor TANF parent resides with the AG. This exemption exists only during the period of shared residence.

Deprivation of all children in the AG is based solely upon the unemployment of their parents.

For ADCR, ADCU, and ADCI only, there is no exemption from assignment or collection of child support paid in behalf of recipient children or adults. Should support be received from a parent for a participating TANF AG member in one of the situations listed above, it is subject to collection by the Child Support Bureau.

An exemption granted from pursuit of support against one absent parent does not automatically exempt the entire case. In the event the case involves more than one absent parent, all absent parents must qualify for an exemption in order to exempt the entire case. If one absent parent in the case and his child qualify for an exemption, while other absent parents in the case and their children do not, the normal

procedures for completing and processing information regarding the nonexempt absent parent are to be followed.

2436.10.10 Child Support Good Cause Exemptions (C)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

A parent/caretaker relative may have good cause for refusing to cooperate in child support enforcement activities, and thus be exempt from the cooperation requirement. Good cause exists when cooperation would be against the best interests of the child. (f96)

Each parent/caretaker relative subject to the cooperation requirement is to be informed of his right to claim good cause **prior** to the requiring of cooperation. If the parent/caretaker relative wishes to make a claim, he must provide corroborative evidence to establish the existence of the good cause circumstance and, if requested, provide sufficient information to permit the Local Office to conduct an investigation. (f97)

Assistance is not to be denied, delayed, or discontinued depending upon a good cause claim determination on cooperation, if all other eligibility requirements are met. (f98)

The Child Support Bureau will not undertake activities to establish paternity or to secure support when notified that an individual has claimed good cause.

The determination of whether or not good cause exists will be made by the Family Independence Section. Within 45 days of the date on which the good cause claim is made, a determination is to be made. (f99)

2436.10.10.05 Child Support Good Cause Circumstances (C)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

Good cause may be established if cooperation by the parent/caretaker relative would be against the best interests of the child only if:

The parent/caretaker relative's cooperation in establishing paternity or securing support can reasonably be anticipated to result in:

- physical harm to the child for whom support is to be sought;

- emotional harm to the child for whom support is to be sought;

- physical harm to the parent/caretaker relative with whom the child is living, which reduces the parent/caretaker relative's capacity to adequately care for the child; or

- emotional harm to the parent/caretaker relative with whom the child is living, of such nature or degree that it reduces the parent/caretaker relative's capacity to adequately care for the child.

Proceeding to establish paternity or to secure support would be detrimental to the child due to the existence of **at least one of the following circumstances**:

- The child for whom support is sought was conceived as a result of incest or forcible rape;

- legal proceedings for the adoption of the child are pending before a court of competent jurisdiction; or

- the parent is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or to relinquish him for adoption **and** the discussions have not gone on for more than three months. (f100)

2436.10.10.10 Child Support Good Cause Considerations (C)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

Physical and emotional harm must be of a serious nature in order to justify a finding of good cause. (f101)

Emotional harm is based upon demonstration of an emotional impairment that substantially affects the individual's functioning. The following factors are to be considered when emotional harm to the child or parent/caretaker relative is claimed:

The present emotional state of the person subject to emotional harm;

the emotional health history of that person;

the intensity and probably duration of the emotional upset;

the degree of cooperation required by the parent/caretaker relative; and

the extent of involvement of the child in paternity establishment or support enforcement activities. (f102)

2436.10.10.15 Child Support Good Cause Corroborative Evidence (C)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

The parent/caretaker relative claiming good cause is to receive Form 948, Notice of Good Cause. The parent/caretaker is to provide a signed statement regarding the reasons good cause is claimed and also provide corroborative evidence to establish the claim. Evidence is to be submitted no more than 20 days from the date on which the good cause claim was made. (f103) A good cause claim may be corroborated with the following types of evidence:

Birth certificate or medical or law enforcement records which indicate that the child was conceived as the result of incest or forcible rape;

court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction;

court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the absent parent might inflict physical or emotional harm on the child or caretaker;

medical records or records of a mental health professional which indicate emotional health history or the present emotional state of the caretaker or child subject to emotional harm;

a written statement from a public or licensed private social agency that the applicant/recipient is being assisted by the agency to resolve the issue of whether to keep the child or relinquish him for adoption; or

sworn statements from individuals other than the caretaker with knowledge of the circumstances which provide the basis for the good cause claim.

In addition, if the evidence submitted is insufficient to establish good cause, the Local Office is to:

Promptly notify the caretaker that additional evidence is required;

advise him of the type of documents needed and how to obtain the necessary documents; and

make a reasonable effort to obtain any specific documents which he cannot reasonably obtain without assistance.

Further, the Local Office **may** conduct its own investigation by contacting the absent parent or alleged father, if such contact is necessary to establish the good cause claim.

Prior to making contact, the caretaker is to be notified so that he may:

Present additional corroborative evidence or information so that contact with the parent or alleged father will be unnecessary;

withdraw the application for assistance or have the case closed; or

have the good cause claim denied.

2436.10.10.20 Evaluation Of Child Support Good Cause Claim (C)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

All good cause claims are reviewed by the Family Independence Section (refer to Section 2436.10.10) to determine whether good cause exists. The good cause decision is then entered into ICES on the AEIAC screen.

The good cause claim is to be approved if the statements and evidence substantiate potential harm to the child or parent/caretaker if child support is pursued.

2436.10.10.25 Child Support Good Cause Determination (C)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

A written notice must be sent to the applicant/recipient following the final decision on the good cause claim.

If good cause is not approved, the notice must include the following:

The decision that good cause does not exist and the basis for the findings;

his right to appeal this decision;

he must cooperate with the child support collection effort if his needs are to be included in the grant; and

his right to withdraw the application or have the case closed. (f104)

If the claim is approved, cooperation is not required. If the claim is denied, the parent/caretaker relative is required to cooperate. (See Section 2436.20.00)

2436.10.10.30 Review Of Child Support Good Cause Determination (C)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

At the time of each redetermination, the Local Office must review any good cause determination based on a circumstance subject to change. (f105) If good cause no longer exists, the original finding of good cause is to be rescinded and the cooperation requirement enforced. The caseworker is to record on screen CLRC the evidence reviewed.

2436.15.00 CHILD SUPPORT NON-COOPERATION (C)

Within the C category, the policy stated in this section only applies to ADCU and ADCR.

Non-cooperation is determined by the prosecutor’s office and they will notify the caseworker of any non-cooperation through the agreed upon procedures.

2436.15.05 Blood Test Results (C)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

When the prosecutor determines that a child's alleged father is excluded by blood tests, they will notify the recipient of the paternity exclusion and the requirement to name all men who could have fathered the child in question. Ten days is given to provide this additional information. Information regarding the penalty for failure to cooperate is also included on the notice.

2436.20.00 PENALTIES FOR CHILD SUPPORT NON-COOPERATION (C)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

Penalties for non-cooperation are applied only when the caseworker receives notification from the prosecutor's office that the action is required. These penalties are discussed in the following sections.

2436.20.05 TANF Penalties For Child Support Non-Cooperation (C)

When the prosecutor's office determines that the parent/caretaker relative with whom the TANF child is living refuses without good cause to cooperate in obtaining support, they will notify the caseworker that he is ineligible for TANF and a sanction should be initiated. (f106)

2436.20.05.05 Medicaid Penalties Relative To IV-D Sanction (MED 2)

IV-D sanctioned TANF recipients do not automatically lose Medicaid eligibility due to the sanction. The reason for the sanction must be reviewed to determine if the sanctioned individual is out of compliance with his/her medical assignment. If the client is found to be out of compliance, appropriate action must be taken. See IPPM Sections 2434.00.00 through 2434.20.05 for information on how to assess and process non-compliance with a medical assignment.

2436.25.00 ENDING CHILD SUPPORT SANCTIONS (C)

Within the C category, the policy stated in this section only applies to ADCU and ADCR.

A sanction must be applied and removed only as directed by the prosecutor's office.

2436.30.00 CHILD SUPPORT MANUAL INFORMATION (C)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

For additional information regarding the Child Support Program, refer to the Child Support Manual.

2438.00.00 WORK REGISTRATION (F)

Work registration is completed when an AG member signs the CAF. Work registration status for all AG members is determined on AEIWP. All mandatory work registrants will be referred to IMPACT.

2438.05.00 IMPACT (F, C, I)

Within the C category the policy stated in this section only applies to ADCR, ADCU, and ADCI.

Indiana Manpower Placement and Comprehensive Training (IMPACT) is the name given to Indiana's Employment and Training Program. IMPACT is the cooperative effort of the Family and Social Services Administration (FSSA), the Department of Workforce Development, the Department of Education, and various other providers which offer employment and training services for TANF and Food Stamp individuals.

Services are designed to assist individuals in overcoming employment barriers due to poor education, absence of marketable skills, and lack of support services, including child care and transportation.

For IMPACT policy and procedures not covered below, refer to Section 2500.00.

2438.05.05 Referral To IMPACT (F, C, I)

During the eligibility interview, the eligibility worker reviews the individual's circumstances and determines whether he/she is IMPACT mandatory or exempt. Refer to Section 2438.15.00 for exemption information. Individuals determined mandatory for participation and exempt individuals wishing to voluntarily participate are referred to IMPACT when the eligibility worker enters the appropriate information on ICES screen AEIWP and authorizes the case. IMPACT referral codes for AEIWP are in ICES Table TWPW.

When an exempt TANF individual volunteers for IMPACT services, he/she demonstrates that any barriers to participation have been overcome, and should be treated as mandatory. Volunteers for TANF IMPACT should be informed that once they volunteer, they are subject to sanction penalties and may not become exempt unless the volunteer is a woman in her 3rd trimester of pregnancy as stated in Section 2438.15.10.05. This does not apply to Food Stamp IMPACT participants.

When an individual receives benefits from both TANF and Food Stamps, the individual is subject only to the TANF IMPACT Program. The individual cannot be referred or served under TANF and Food Stamp IMPACT simultaneously. When the eligibility worker authorizes a referral, the individual will be advised of the rights and responsibilities (see 2438.05.15) via a notice generated from ICES included in the CAF.

Family Case Coordinators are informed of the referral of a new TANF IMPACT participant via alert number 839 or 400 for ABAWD's and should schedule the participant for an

Assessment Interview according to the time frames in Section 2500.00. FS mandatory IMPACT participants are referred through Screen WPRR, the IMPACT Referral Selection.

2438.05.10 IMPACT Service Priorities (F, C, I)

Indiana has established service priorities for IMPACT based on federal requirements for local offices that may lack sufficient staff and/or monetary resources to serve all TANF individuals and Food Stamp recipients or those who volunteer to participate in IMPACT activities.

TANF individuals who do not meet any exemption criteria are mandatory for IMPACT participation and are to be given service priority.

Food Stamp recipients who meet the definition of "able-bodied adults without dependents" (ABAWDS) as identified by the eligibility worker are to be given service priority, as they will have a Food Stamp Benefit time limit imposed if they fail to meet the ABAWD work requirement. Section 2438.17.00 includes ABAWD requirements.

Food Stamp households with mandatory participants who are not ABAWDS are to be given second priority.

Local offices may establish additional service priorities to target specific populations in their county but must ensure that the aforementioned priorities are met first.

2438.05.15 Work Registrant Responsibilities (F, I)

Each work registrant has certain rights and responsibilities. These rights and responsibilities are included on the approval notice when the AG is authorized. This notice also contains the names of the AG members who are work registered.

Each work registrant must:

Respond to requests for more information about employment status or availability for work;

provide sufficient information to allow determination of employment status or job availability;

participate in any employment and training program to which assigned;

report to any employer to whom referred; and

accept any suitable job that pays at least the Federal minimum wage.

Each work registrant must not:

. Voluntarily quit a job without good cause;

. Voluntarily reduce work hours below 30 hours per week without good cause.

2438.05.20 IMPACT Caseworker Responsibilities (F, C, I)

The caseworker must provide, in writing, and explain the following information verbally, to the payee/caretaker relative of the AG or the individual required to participate:

The participation requirements;

each of the exemptions;

the right to a fair hearing to contest the decision that he is required to participate;

the penalties for refusing to participate;

the right to a fair hearing to contest the removal of his needs from the eligibility determination because of his refusal to comply with requirements;

the requirement that changes which would affect IMPACT or E & T status (for example, child age 16 or 17 no longer in school, recovery from illness or incapacity, and so forth) be reported to the Local Office within 10 days of the change;

the right to a fair hearing to contest the denial or withdrawal of IMPACT or E & T supportive services; and

the right of exempt Food Stamp individuals to volunteer for IMPACT or E & T and to withdraw from participation without a loss of benefits.

The payee of the AG is responsible for informing all other AG members required to participate of this information. Other AG members may contact the caseworker for clarification of the information.

2438.05.25 IMPACT Rights and Responsibilities (F, C, I)

Each IMPACT registrant, whether voluntary or mandatory, has certain responsibilities. The AG is informed of these responsibilities on the approved notice which is mailed to the AG.

Each participant in IMPACT has the right to:

Fair and equal treatment in the assignment of employment and training activities;

file a written complaint if he thinks discrimination has occurred;

work out differences with the Family Case Coordinator through conciliation; and

request a hearing if the AG's Food Stamps and/or TANF and Medicaid benefits were reduced, denied, or discontinued.

Each participant in IMPACT has the responsibility to:

Keep scheduled appointments with the Family Case Coordinator;

keep scheduled appointments at other places when sent by the Family Case Coordinator;

participate in all employment and training activities outlined in the Self-Sufficiency Plan; and

accept suitable child care, transportation and other supportive services offered in order to participate in an employment and training activity.

2438.10.00 DETERMINATION OF PARTICIPATION STATUS (F, C, I)

The caseworker must determine IMPACT participation and Work Registration status for applicable individuals. Participation requirements vary by program and are described in the following sections.

2438.10.05 Determination Of Work Registration Status (F, I)

The caseworker must determine which individuals are required to register for work and which are exempt and enter that information on screen AEIWP.

Each individual who is not exempt must be registered prior to approval of the application, and when a new member joins the AG who was not work registered in another AG. When a new member joins the AG who must work register, that member or another adult member must sign the application Part III or CAF to work register the new member. The new member may not be added to the AG until a signature is obtained.

Work registration is completed when a member of the FS AG signs the work registration statement on the application Part III or CAF.

When an individual loses an exemption during the certification period, he must be work registered at the next re-certification.

2438.10.05.05 Postponed Determination Of Work Registration Status (F, I)

For AGs entitled to expedited services, registration of all required individuals may be postponed if registration cannot be accomplished within the expedited service time frames.

If an individual claims an exemption due to a disability that is not apparent and is questionable, the caseworker must postpone verification of the disability if verification cannot be obtained within the expedited service time frames.

2438.10.10 Determination Of IMPACT Participation Status (F, C, I)

ICES will determine the IMPACT participation status (mandatory, exempt, or volunteer) of each individual in the AG. The determination is made based upon the codes the caseworker enters on AEIWP. Exempt individuals are not required to participate. For Food Stamps, individuals who are exempt, but wish to participate, are referred as voluntary participants. For TANF, individuals who are exempt due to age or pregnancy but wish to participate are referred as voluntary participants. All other exempt TANF individuals who wish to participate in IMPACT are referred as mandatory participants because the individual has determined that the reason for the exemption is not a barrier. (Refer to Section 2438.25.00)

Participation status must be determined at the initial application, each redetermination, or upon receipt of information that a change in participation status may have occurred. The caseworker must input the correct referral code for each individual in an AG.

All nonexempt applicants and recipients will be referred to a Family Case Coordinator who is responsible for making an assessment and developing a SSP for the individual.

During application entry, the caseworker must determine if TANF IMPACT referral and/or Food Stamp work registration and IMPACT referral is appropriate for each individual in the case.

Individuals may not be active in both TANF IMPACT and FS IMPACT. An individual who is referred to IMPACT for TANF

must be coded 20 (Exempt-Referred to TANF IMPACT) for work registration if in an FS AG and no other exemption code applies. When the caseworker enters the registration and referral status on AEIWP the first applicable code on Table TWPW must be used.

2438.15.00 EXEMPTIONS FROM WORK REQUIREMENTS (F, C, I)

This section discusses exemptions from participation in the applicable employment and training programs.

2438.15.05 Exemptions From Work Registration (F, I)

Any AG member who meets one or more of the following conditions is exempt from work registration. These conditions also constitute the reasons that an AG member is exempt from IMPACT. Therefore, any individual meeting one or more of the following conditions is exempt from work registration and participation in IMPACT:

under age 16;

age 60 or over;

age 16 or 17, attending school, or enrolled in an employment and training program at least half-time (see 3210.15.35);

age 16 or 17 and not the AG head;

physically or mentally unfit;

responsible for an incapacitated individual;

responsible for care of a dependent child under six;

enrolled student (at least half-time)(see 3210.15.35);

drug/alcohol treatment program participant;

complying with Cash Assistance IMPACT requirements;

receiving unemployment compensation;

employees under contract (school employees, migrants);

working a minimum of 30 hours a week or equivalent; or

earning the federal minimum wage amount times 30 hours

Additional information on these exemptions are provided in the following sections.

2438.15.05.05 Individuals Under Sixteen Years Of Age (F, I)

Individuals under 16 are exempt from work registration. Individuals whose 16th birthday occurs during the entitlement period will be required to register as part of the next scheduled redetermination process, unless qualified for another exemption. The individual's statement of age is accepted, unless questionable. This policy is for all AG members who turn 16 during a certification period because this is a change the AG is not required to report.

2438.15.05.10 Individuals Age Sixty Or Over (F, I)

Individuals age 60 or over are exempt from work registration. The individual's statement of age is accepted, unless questionable. Workers, who receive an alert to run AEABC, be sure to change status to 10 on AEIWP.

2438.15.05.15 Individuals Age Sixteen Or Seventeen And Attending School (F, I)

An individual age 16 or 17 is exempt if the individual is:

Not the head of the AG; or

is attending school or enrolled in an employment and training program on at least a half-time basis.

The individual's statement is acceptable verification unless questioned.

2438.15.05.20 Individuals Physically Or Mentally Unfit For Employment (F, I)

An individual who has a physical or mental impairment resulting from, but are not limited to illness, addiction, injury, or domestic violence which prevents entry into employment or training is exempt from work registration. Verification is required if a mental or physical impairment is claimed, but not evident. The caseworker must assist the individual in obtaining verification. Verification may consist of:

a statement signed by a physician, physician's assistant, nurse, nurse practitioner, designated representative of the physician's office, a licensed or certified psychologist, a social worker, or any other medical personnel the local office worker determines appropriate stating that the individual is unable to work due to the specific illness, and for what length of time the individual is expected to be unable to work; or

a receipt of temporary or permanent disability benefits issued by government or private sources.

Receipt of benefits for partial or marginal disability may indicate only that the individual is not suitable for certain jobs. Other jobs may exist that the individual is physically and mentally capable of handling. In this situation, the individual is not automatically exempt. Determination for registration is made on a case-by-case basis in these instances.

2438.15.05.25 Care Of An Incapacitated Individual (F, I)

Individuals responsible for the care of an incapacitated individual are exempt. The incapacitated individual may or may not be an AG member. In addition, the incapacitated individual need not reside with the AG. No documentation of the incapacity is required unless it is questioned. If questionable, a physician's statement or other appropriate documentation may be used.

2438.15.05.30 Individuals Responsible For Care Of Dependent Child (F, I)

An individual responsible for the care of a dependent child under age six is exempt. If the AG consists of a married couple, only one parent may be exempt for this exemption for a common child.

In an AG where there are two families functioning as one and each parent is responsible for his own child, both parents may be eligible for this exemption.

If the child's sixth birthday occurs during the entitlement period, work registration is required as part of the next redetermination unless another exemption is met.

2438.15.05.35 Students (F, I)

Students enrolled on at least a half-time basis (as defined by the institution) in any recognized school, training program, or institution of higher education, are exempt. Enrollment in a mail, self-study, or correspondence course does not qualify an individual for this exemption. Verification of enrollment and number of hours is required.

Students remain exempt during normal periods of class attendance, vacation, and recess, unless the student graduates, is suspended or expelled, drops out, or does not intend to register for the next normal school term.

2438.15.05.40 Participants In Drug Addiction/Alcoholic Treatment (F, I)

Individuals enrolled and participating in a drug addiction or alcoholic treatment and rehabilitation program are exempt. The individual does not have to be a resident of

the center. The exemption also applies to persons participating in an outpatient program.

2438.15.05.45 Cash Recipients Complying With Work Requirements (F, I)

Individuals subject to and complying with any work requirement under Title IV of the Social Security Act, including TANF IMPACT, are exempt from the FS requirement since they are subject to the TANF IMPACT requirements.

Individuals who fail to comply with any requirements of TANF IMPACT which are comparable to the requirements of FS IMPACT will be disqualified for FS, provided the registrant does not meet another FS work registration exemption.

2438.15.05.50 Individuals Receiving Unemployment Compensation (F, I)

Individuals receiving unemployment compensation are exempt. They must be receiving benefits, or be eligible to receive them, to be exempt under this criteria.

2438.15.05.55 School Employees Under Contract (F, I)

Employees under contract are exempt during the non-work season if they meet one of the following conditions:

If total annual wages equal the federal minimum wage multiplied by 1560 (52 weeks times 30 hours);

if the total number of hours worked equals or exceed 1560 (52 weeks times 30 hours); or

seasonal farm workers (migrants) under contract or similar agreement with an employer to begin work within 30 days.

2438.15.05.60 Individuals Working Minimum Of Thirty Hours Weekly (F, I)

Individuals are exempt if employed or self-employed and meet one of the following criteria:

Working a minimum of 30 hours per week;

receiving earnings equal to or greater than the federal minimum wage multiplied by 30 hours, or the training wage multiplied by 30 hours if the employment situation warrants the payment of a training wage; or

migrant or seasonal farm workers under contract or similar agreement with an employer to begin work within 30 days.

When determining whether a self-employed individual is exempt on this criteria, the caseworker may use the following information:

Income alone may be sufficient;

If the income does not equal the federal minimum wage multiplied by 30 (i.e., babysitting), but the individual claims he works 30 hours per week, the individual must cooperate with the caseworker to establish that the volume of work equals 30 hours per week;

Individuals engaged in hobbies or volunteer work (exceptions are VISTA or ACTION) or any other activity which does not generate sufficient income, cannot be considered gainfully employed and cannot be exempt from work registration regardless of the number of hours spent in the activity; or

When the self-employed individual hires or contracts with another individual or firm to handle daily activities of the enterprise, the individual cannot be considered self-employed unless the individual works at least 30 hours weekly in the activity.

2438.15.10 Exemptions From IMPACT (F, I)

These exemptions apply to mandatory work registrants who are referred to IMPACT. This would be coded on AEIWP as 01 under Food Stamp work registration with the appropriate exemption code under FS referral.

An AG member is exempt from participation in IMPACT if the member does not have adequate transportation. This will include individuals who do not own a vehicle and do not have access to a vehicle belonging to someone else, and do not live near a bus line, and do not live within walking distance (one mile) of an IMPACT component site, and cannot obtain transportation for $100 per month or less in order to participate.

An AG member is also exempt from IMPACT if the monthly costs of participation in IMPACT Activities exceeds the reimbursement limits. These limits are $200 per dependent under two and $175 per month for other dependents for dependent care and a total of $100 per month for all other supportive services, including transportation.

An AG member is also exempt from IMPACT if she is in her second or third trimester of pregnancy. Work registration is still required under this condition but the IMPACT requirement is exempted. After delivery, the individual

would then be exempt from work registration for a child under age six.

2438.15.10.05 Exemptions From IMPACT (C, I)

The policy in this section affects the ADCU and ADCR categories.

TANF recipients are exempt from participating in IMPACT activities if they meet one or more of the following criteria:

Under age 16;

Full-time student (as defined by the school) at an elementary or secondary school who is age 16 or 17 and not a minor parent TANF case head;

Age 60 or older;

In the third trimester of pregnancy as verified (in writing) by a licensed medical professional; (f107a)

Needed in the home to provide care for a child who is less than 12 weeks of age; (f107b)

In the application process for Supplemental Security Income (SSI); (f107c)

Receiving SSI, Social Security Disability Assistance (SSDA), or other assistance due to disability; (f107d)

Eligible for Medicaid for the disabled or blind. (f107e)

Per the Personal Responsibility and Work Opportunity and Reconciliation Act of 1996 all individuals are subject to the 60-Month Federal time limit regardless of their IMPACT status. As such those individuals who are determined to be exempt from IMPACT are to be provided services that will assist them in overcoming this barrier preventing them from self-sufficiency.

(NOTE: With the exception of the exemption for persons age 60 and over, the circumstances which cause the exemptions to be allowed are subject to change. Therefore, it is necessary to review the exemption circumstances at each 6 month redetermination of eligibility to determine whether the recipient’s exempt status should be revoked or maintained.)

Information regarding an individual’s IMPACT status is captured on the ICES Work Program Registration/Referral Screen (AEIWP). In the TANF Referral Code field, the

caseworker enters a code number obtained from Table TWPW which corresponds to the individual's exemption reason. The system then displays the TANF IMPACT status as "E" for Exempt.

When an individual has been exempted due the care of a young child, the care of an incapacitated family member, or total inability to work, and the individual begins working or indicates that she/he is able to participate in an employment activity, the exemption is considered to cease as the individual is able to overcome the situation which previously existed. The "E" TANF IMPACT status code is unprotected, thereby allowing the caseworker to change the individual's status from "E" for exempt to "M" for mandatory.

2438.15.10.10 Exemptions From Employment And Training Participation (C)

The policy in this section affects the ADCQ category for Refugee Cash Assistance (RCA).

Recipients of Refugee Cash Assistance (ADCQ) are exempt from participation in employment and training activities for refugees if they meet one or more of the following criteria:

Under age 16;

Full-time student (as defined by the school) age 16 or 17 at an elementary or secondary school;

Age 65 or older;

Completely unable to work. The condition can be the result of many things including but not limited to illness, addiction or injury, including domestic violence. Documentation of the physical and/or mental condition is needed as well as an explanation of how and why the condition prevents employment;

Required presence in the home on a continuous basis to care for an ill or incapacitated household member, if there is no appropriate caregiver in the home. The need for the recipient's presence as caregiver must be verified by a physician or qualified psychologist;

Working 30 or more hours per week;

An RCA recipient who is determined to be mandatory and who subsequently starts employment of 30 or more hours per week, either through E & T or on his own, does not become exempt as a result of becoming employed. The individual remains mandatory and employment is their E & T

activity. They should be encouraged to increase hours, seek promotions or raises, etc., to bring their family to self-sufficiency.

Pregnancy in second or third trimester as verified (in writing) by a licensed medical professional;

Caretaker of a child under age six for ADCQ;

This exemption is not available if the parent is under age 20 and does not have a high school diploma or GED.

(NOTE: With the exception of the exemption for persons age 65 and over, the circumstances which cause the exemptions to be allowed are subject to change. Therefore, it is necessary to review the exemption circumstances no less frequently than every 6 months to determine whether the recipient's exempt status should be revoked or maintained.)

RCA (ADCQ) recipients who, although they are exempt from the requirement to participate, wish to do so of their own volition are to be referred to E & T as volunteers. It is important for the caseworker to inform an exempt person wishing to volunteer that once referred to E & T, failure to participate in assigned activities could (if good cause did not exist) result in sanction (see 2438.45.35.10).

2438.17.00ABLE BODIED ADULTS WITHOUT DEPENDENTS (F, I)

Any Able Bodied Adult without Dependents (ABAWD) who is between the ages of 18 and 50 (those age 18 to and including age 49) cannot receive food stamps for more than 3 months out of 36 months without complying with work requirements. The time period is a fixed clock which starts October 1, 2005 and ends September 30, 2008. A new 3 year period would then start on October 1, 2008. When an individual has received 3 months of benefits without complying and non-compliance is expected to continue, he/she will be determined ineligible. (f108) His/Her income, resources and expenses will continue to be included in the Food Stamp budget if others are in the AG.

An individual may regain eligibility under certain circumstances.

ABAWD status is coded on ICES screen AEABA. The status is determined at initial application, redetermination or when an individual is added to the case. The system auto-fills the codes on AEABA but a supervisor has override capability. Any ABAWD countable months that were used out of state must be verified and entered on AEABA.

When Food Stamp benefits are prorated, that is not counted

(coded as 'P' on AEABA) as 1 of the 3 non-compliant months. When ever an ABAWD has collected 3 'M' codes or more on AEABA, code 'P' cannot be used again.

Additionally, if the individual does not receive Food Stamps in a month that month is not counted (coded as 'N' on AEABA) in the 3 month compliance determination. This includes months where the individual was sanctioned but continues to be a household member. This also includes an ABAWD who is coded as 'M' on AEABA but did not participate in that month. The worker would check IQES and IQFS to determine this status.

Food Stamp benefits erroneously received by an ABAWD shall be counted unless or until the ABAWD pays it back in full.

2438.17.05 ABAWD Exemptions (F, I)

An individual between the ages of 18-49 is exempt from ABAWD work requirements (f109) if he is:

Exempt from work registration requirement. (See Manual Section 2438.15.05.); or

Physically or mentally unfit for employment. If the individual is not obviously unfit, it must be verified by one of the following: physician, physician's assistant, nurse, nurse practitioner, designated representative of the physician's office, a licensed or certified psychologist, a social worker, or any other medical personnel the local office worker determines appropriate to state the client is physically or mentally unfit for employment/work due to the specific illness, and for what length of time the individual is expected to be unable to work; or

Living in the same FS AG that contains a dependent child age 17 or younger.

ABAWDS are also exempt from the ABAWD work requirement if they live in a county or city (listed below for the time period of 4/01/08 through 3/31/09) which has been approved as a waivered labor surplus area by Food and Nutrition Service (FNS) and accepted by the Division of Family Resources (DFR).

COUNTIES

Blackford	Lawrence
Brown	Madison
Cass	Miami
Clay	Newton
Crawford	Noble
Dearborn	Ohio

Decatur	Orange
Dekalb	Owen
Delaware	Parke
Fayette	Pulaski
Floyd	Putnam
Franklin	Randolph
Fulton	Ripley
Grant	Scott
Greene	Starke
Henry	Steuben
Howard	Sullivan
Huntington	Tipton
Jackson	Union
Jasper	Vermillion
Jay	Vigo
Jefferson	Wabash
Jennings	Washington
Lake	Wayne
LaGrange	Whitley
LaPorte	

CITIES

Elkhart	South Bend

The individual must reside within the city limits to be exempt for living in a labor surplus city;

Pregnant (any trimester).

If an individual is or was correctly projected to be exempt for any portion of a month, the exemption covers the entire month.

If an individual is not exempt due to one of the above reasons, the ABAWD should be coded as "03" on AEIWP. However, ABAWDS living in a labor surplus area are coded as 03 on AEIWP since they receive their exemption from the ABAWD work requirement on AEABA with code L.

2438.17.10ABAWD 15% Exemption Waiver (F)

This exemption will be given in situations where an ABAWD is not in compliance with the ABAWD provision. An additional 3 months of eligibility will be given to ABAWDS and this will be denoted by using code 'Z' on screen AEABA. Therefore, an ABAWD will be able to receive 6 months of FS in a noncompliant status during the 3 year, fixed clock period. (Three months of Code M and three months of Code Z, they do not have to be consecutive months.) This code should be used on screen AEABA for the following reasons:

ABAWDS who are currently on assistance and are ready to start their 4th month of noncompliance with the ABAWD work requirement; or

ABAWDS who have received 3 months of Food Stamps in the 3 year, fixed clock period while being noncompliant with the ABAWD work requirement and they are reapplying for Food Stamps.

Alert 884 will be received by the worker when 3 M codes have been received on AEABA

Alert 892 will be received when the ABAWD has received 3 Z codes on AEABA and Code F is currently displaying on AEABA. The worker will have to run AEABC and authorize the case for the ABAWD failure to become effective.

Code 'Z' will never be used for a retroactive (except for supervisory override) month. Code 'Z' should not be confused with code 'X' which is the one time, 3 consecutive month extension.

Code 'X' is used before code 'Z' if the client is eligible to receive either one.

Code 'P' is never appropriate for a prorated month if the ABAWD has 3 M codes or more. Code 'Z' would then be used if eligible.

If an ABAWD is currently serving an IMPACT sanction, that must be cured first before the ABAWD may receive the 3 additional months of eligibility (code X or Z).

ABAWD's must be given timely notice of adverse action when noncompliance occurs during the 3 year, fixed clock period. If compliance is projected and the worker subsequently discovers the ABAWD was noncompliant, timely notice of adverse action still must be given. A claim would be established for any benefits issued beyond the allowable time period.

2438.17.15Regaining Eligibility For ABAWD (F)

After an individual loses eligibility for failure to comply with the ABAWD work requirement, he may regain ABAWD eligibility although he/she may not be eligible for Food Stamps. There is no limit on how many times an individual may regain eligibility and subsequently maintain eligibility by meeting the work requirement.

To regain eligibility, the individual must comply with one of the following:

Working (including self-employment or volunteer work) at least 80 hours in a 30 day period;

Participating and comply with the Workforce Investment Act (WIA), Trade Adjustment Assistance Act Program (TAA) or IMPACT (other than Job Search or Job Search Training) at least 80 hours in a 30 day period;

Works and in combination with IMPACT, WIA, TAA attains 80 hours in a 30 day period;

Participate in an appropriate amount of CWEP hours (FS AG benefit amount divided by the minimum wage = hours per week to work to meet CWEP requirement). The local office will need to develop an offline procedure for the ABAWD to use this method to regain eligibility. Document the off line determination in CLRC or CLSC.

If a person becomes exempt from work registration or meets one of the ABAWD exemptions in 2438.17.05, he/she is exempt from ABAWD requirements. However, if the person later loses his/her exemption, he/she must still meet 1 of the 4 criteria above to become ABAWD compliant.

2438.17.20ABAWD 1 Time, 3 Month Extension (F)

If an individual has used 3 months of ABAWD eligibility in a noncompliant status (code M) and regains eligibility by meeting 1 of the 4 criteria in IPPM 2438.17.15, and then loses his/her position, or hours are reduced to less than 20 hours per week, the individual is entitled to a 1 time, 3 month extension. (f109a) (If an individual meets a work registration or ABAWD exemption, there is no need for the extension.)

The 3 months will run consecutively once it has begun. All other eligibility criteria must be met in order to receive Food Stamps during the extension. If the individual cannot use the 3 month extension (i.e., client has a voluntary quit penalty that would override the 3 month extension of eligibility), then the extension will not be coded on AEABA (code 'N' would be used in this situation). However, once the extension does begin, it continues to run whether or not the client is eligible to receive Food Stamp benefits.

The extension is allowed only one time in a 36 month period. If it has been used, the individual can only regain eligibility by complying with the requirements in IPPM 2437.17.15.

An individual may avoid using the 1 time, 3 month consecutive month extension by withdrawing from the program before the effective date of the extension. If the individual is a mandatory member of an AG, the entire AG

must withdraw.

2438.17.25ABAWD Redeterminations (F)

If no changes were reported for the past certification period at the redetermination interview, it is not necessary to re-verify the ABAWD status projected at the last certification.

If the ABAWD status needs to be corrected, check the status for the previous cert period to verify if the status was correct at that certification period. If the status was correct for that cert period, the status does not need to be corrected before that point.

2438.17.30Change Processing - ABAWD (F)

If a new member joins the AG, his/her status must be determined and verified before he/she is added to the AG.

If compliance is projected for the following month as the result of a reported change for a person who is currently certified, continue benefits based on that projection even though 3 or more months of benefits were received in a mandatory noncompliant status during the 3 year, fixed clock period.

The system will auto fill screen AEABA in one of 2 ways:

The system will calculate monthly on a batch run the first Friday of every month; or

Anytime the worker accesses AEABA.

The system will calculate 2 codes (current calendar month's code and the next calendar month's code). Supervisors will always have override capability of any system determined code.

If an ABAWD is being added to an existing AG, the code for the first month must be overridden (use code N). The system will code the ABAWD as receiving benefits for that month when the AG doesn't receive benefits for the addition of the ABAWD until month after the report.

2438.17.35Food Stamp IMPACT Compliance (F, I)

Food Stamp clients are considered to be in compliance with IMPACT employment and training requirements unless they, without good cause:

Fail to meet Applicant Job Search responsibilities;

fail to attend an assessment employability plan development interview;

fail to cooperate with any employment and training agency whose services are included on the employability plan; or,

fail to attend 100% of the scheduled hours for any activity.

The FCC is responsible for identifying and documenting the above non-compliances, determining good cause, and when appropriate, requesting a sanction.

2438.17.40 Compliance With ABAWD/IMPACT (F, I)

An individual is in compliance with ABAWD requirements when he/she:

Is participating in and complying at least 20 hours per week on average with one of the following:

Any program of the Workforce Investment Act (WIA)
Trade Adjustment Assistance Act Program
IMPACT (other than Job Search or Job Search Training);or

Is working/participating and complying with one or more of the above, for a total of 20 hours per week on average for the month. Hours worked must be verified.

Additionally, an ABAWD is considered compliant if participating in a CWEP activity (which can be less than 20 hours per week). The hours are determined by dividing the FS allotment for the AG by the federal minimum wage and rounding to the next full dollar.

The individual remains in compliance if he/she continues to meet the above provisions or becomes exempt from work registration/ABAWD requirements. If changes in work hours decrease below 20 hours per week, (averaging monthly hours) the ABAWD must report the change. This is the one exception to simplified reporting where the ABAWD must report. If the individual is doing less than 80 hours per month but has good cause, then the ABAWD is considered in compliance. An example of this is when an ABAWD may miss work due to sickness or has good cause for missing an IMPACT activity.

Compliance may be projected for all ABAWDs whether or not they have used their months of ABAWD eligibility. The determining factor is if the ABAWD has a job or IMPACT activity line up that will meet the ABAWD work requirement.

If an individual fails to comply with IMPACT activities addressed in their self-sufficiency plan, he/she is sanctioned for failure to comply with IMPACT.

2438.20.00 NON-COMPLIANCE WITH WORK REGISTRATION (F, I)

If the AG head or an individual AG member fails to meet work registration requirements, penalties described in Section 2438.45.15 are imposed. Those work registration requirements are to:

Work register when required;

provide sufficient information to allow determination of employment status or job availability;

respond to a request for more information about employment status or availability for work;

report to an employer to whom he is referred by the FCC;

accept a suitable job. (Refer to Section 2438.45.10.10);

do not voluntarily quit a job without good cause; and

do not voluntarily reduce work hours to less than 30 per week without good cause.

2438.20.05 Cure For Work Registration Non-Compliance (F)

An individual who has been disqualified for non-compliance with a work registration requirement may cure the non-compliance and become eligible by becoming exempt from work registration or by serving the minimum sanction period and complying with the following requirements:

NON-COMPLIANT BEHAVIOR	COMPLIANT BEHAVIOR
Refusal to register.	Registration by the AG member.
Refusal to respond to a request from a PAC/FCC for supplemental information regarding employment status or availability for work.	Compliance with the request from a PAC/FCC for supplemental information regarding employment status or availability for work.
Refusal to report to an employer to whom referred or refusal to accept a bona fide offer of suitable employment to which referred.	Report to this employer if work is still available or to another employer to whom referred or acceptance of the employment if still available

	or acquire other employment comparable to the refused job or other employment of at least 30 hours per week but with weekly earnings equal to the Federal minimum wage multiplied by 30 hours.
Voluntary Quit or Reduction	Obtain employment comparable in salary or hours to the job that was quit/reduced.
Refusal to comply with IMPACT	Compliance with the assignment or an alternative assignment.

All these acts of non-compliance will be shown as a sanction for Food Stamps on AEOIE. The sanction will be initiated by the FCC if the non-compliance involves the SSP.

The PAC will code the non-compliance on AEIWP and initiate the sanction.

When the non-compliant behavior is cured, an end date must be entered on AEOIE by the worker (PAC or FCC) who initiated the sanction.

2438.25.00 VOLUNTARY IMPACT PARTICIPATION (F, C, I)

For Food Stamps, ADCR, ADCU, and ADCI, applicants/recipients who are exempt from participation in the IMPACT Program may be given the opportunity to do so on a voluntary basis. The option to participate voluntarily should be based upon policies that are fair, equitable, and in accordance with the county's IMPACT Service Plan. For TANF individuals who are exempt due to age or pregnancy but wish to participate are referred as voluntary participants. To volunteer an exempt TANF individual, the caseworker will indicate the correct exemption code for TANF on AEIWP and indicate "V" under TANF status. All other exempt TANF individuals who wish to participate in IMPACT are referred as mandatory participants because the individual has determined that the reason for the exemption is not a barrier. To volunteer an exempt FS individual, indicate the correct WR exemption code and code "?" under FS referral status.

A volunteer who is eligible for TANF and FS must be assigned to the TANF Program.

Additionally, refugees in the ADCQ category of assistance may volunteer for E & T services even though they are exempt from participation.

2438.30.00 LOSS OF EXEMPTION WHILE CERTIFIED (F, I)

Individuals who lose work registration exemption status due to a change in circumstance that has been or must be reported will be required to register for employment when such a change occurs. Examples of changes are:

Loss of employment; or

an exemption was granted to an AG member to care for a child and the child leaves the home.

The caseworker must change the exemption status in ICES on AEIWP when the change occurs. The case must be authorized or the work registration status change will not take effect.

If a change occurs which is not required to be reported, the registration will occur at the redetermination.

2438.35.00 IMPACT PARTICIPATION STATUS RE-EVALUATION (C, I)

Reported changes which affect an individual's IMPACT participation status are entered by the caseworker into ICES. Examples of changes that must be reported are:

a gain or loss of employment;
address change; or
birth of a child

ICES generates an alert to the FCC when changes affecting participation status are reported.

At each redetermination, the Local Office will also re-evaluate any exemptions which are not considered to be permanent in nature. A review in less than six months is indicated whenever there is reason to believe that the condition or circumstance which made the exemption necessary, has terminated. (f110) (Refer to Section 2215.15.00)

2438.40.00 FCC RESPONSIBILITIES (F, C, I)

The FCC is responsible for assessment and placement activity for each participant. The FCC is also responsible for determining good cause when an individual fails to cooperate with an IMPACT activity. (Refer to Section 2438.45.10 and 2438.05.10.05)

2438.45.00 NON-COMPLIANCE WITH IMPACT/E & T (F, C, I)

Non-compliance not only applies to the participant’s involvement or participation in activities scheduled by or with the FCC, but also with the IMPACT contractor. When TANF or FS IMPACT mandatory individual, voluntary FS individual or ABAWD does not comply with IMPACT, the FCC

must complete and send the Notice of IMPACT Non-compliance, State Form 25385. The Notice must be sent within two days of receiving information or noting that the participant is non-compliant. The Notice must include the following:

Name of participant who is out of compliance;

Specifically why the participant is considered to be non-compliant – mention SSP if appropriate;

When the non-compliance occurred;

Deadline for participant's response which is 13 calendar days from the date the Notice is mailed. If the 13th day is a weekend or holiday, the deadline is the first working day after the weekend or the holiday; and

Indicate the applicable program, TANF or FS.

Complete all other blanks: deadline for the participant to avoid losing FS benefits, signature and phone number of the FCC and date signed.

If the participant did not respond by the deadline stated on the Notice or did respond, but the FCC did not find good cause, the IMPACT sanction should be initiated and case authorized.

If the participant did respond by the deadline and the FCC agrees that the participant has good cause, the FCC should document the good cause and take steps to schedule the participant as soon as the circumstance that resulted in good cause no longer exists.

A voluntary FS IMPACT should not be sanctioned, instead, he/she must be discontinued from IMPACT participation and notified of the discontinuance.

For ADCQ, the caseworker acts on a noncompliance reported by the Employment and Training Contractor by entering the information on the Alien Information Screen (AEICZ). Sanctioning is discussed in Sections 2438.45.35.05 and 2438.45.35.15 and 2438.45.35.20.

2438.45.10 Work Registration Good Cause Determination (F, I)

The guidelines for determining good cause for failure to meet work registration requirements are listed below:

Work Registering - the AG shall be considered to have good cause if the AG member was:

Not notified of the requirement to do so;

did not receive the written notice; or

a subsequent occurrence rendered the AG member exempt from work registration.

Provide sufficient information to allow determination of employment status or job availability or provide response to a request for more information about employment status or availability for work - the AG member shall be considered to have good cause if the AG member:

Did not receive the written request; or

a subsequent occurrence rendered the AG member exempt from work registration.

Reporting to an employer when referred by the worker, case manager, or contracted service provider - the AG member shall be considered to have good cause if any of the following criteria are met:

Personal illness, illness of another AG member requiring the registrant's presence in the home, or the death of an immediate family member. A physician's statement may be required if personal illness is given as the reason for failure to report;

a household emergency which threatens injury to a person or damage to property such as a natural gas or water leak or fire;

the lack of transportation, either because none is available or available transportation is nonfunctioning;

the lack of adequate child care;

inclement weather conditions which could threaten the health of the individual; or

a subsequent occurrence rendered the AG member exempt from work registration.

Declining a job - the AG member shall be considered to have good cause if any of the following criteria are met:

Job was less than minimum wage or, if receiving a training wage, less than $3.35;

job was further than walking distance (one mile) and no public or private transportation was available;

job involved a health risk for that person;

job required illegal activity;

job required that the AG member join, resign from, or refrain from joining any legitimate labor organization to keep the job;

job hours or responsibilities interfere with religious beliefs;

the AG member was physically or mentally unfit to perform the responsibilities specific to this job;

the AG member lives a distance that required more than one hour's travel (one way) to the job, not including the transporting of a child to and from a child care facility;

job was offered within the first 30 days of registration and was not in the AG member's major field of experience; or

a subsequent occurrence rendered the AG member exempt from work registration.

See Section 2438.50 and all sub-sections of 2438.50 for good cause for voluntary quit and voluntary reduction of hours.

2438.45.10.05 IMPACT Good Cause Determination (F, I)

The IMPACT FCC must explore possible good cause reasons with each registrant to determine if good cause exists for failure to comply with an IMPACT requirement. Good cause includes circumstances beyond the individual's control including, but not limited to:

Illness;

illness of another AG member requiring the presence of the individual in the home;

an AG emergency situation involving the client which presented immediate risk to the health or safety of the client or others. This would include, but is not limited to instance of domestic violence;

the unavailability of transportation;

lack of adequate child care for children between six and 12, including situations where child care costs would reduce the individual's expected job income to an unacceptable level;

individuals who reside an unreasonable distance from potential employment (one hour each way);

individuals who reside in a remote area;

individual became exempt from work registration or IMPACT requirements;

required court appearance; or

expedited AGs certified for one month.

If the non-cooperation involves failure to accept employment, the FCC must determine if the job is unsuitable. Employment is unsuitable if it meets any of the conditions described in the following section.

2438.45.10.10 Suitable Employment (F, I)

Employment will be considered unsuitable if the following applies:

The wage offered is less than the highest of the applicable federal minimum wage, or 80 percent of the federal minimum wage if the federal minimum wage is not applicable.

The employment offered is on a piece-rate basis, and the average hourly yield the employee can reasonably be expected to earn is less than the applicable hourly wages specified above.

The AG member, as a condition of employment or continuing employment, is required to join, resign from, or refrain from joining any legitimate labor organization.

The work offered is at a site subject to a strike or lockout at the time of offer, unless the strike has been declared unlawful.

All other employment will be considered suitable unless the registrant can demonstrate that:

The degree of risk to health and safety is unreasonable;

the individual is physically or mentally unfit to perform the employment, as documented by a signed physician's statement, medical evidence, or by reliable information from other sources such as employer statement regarding the medical verification he has received;

the employment offered within the first 30 days of registration is not in the individual's major field of experience;

cost of commuting from individual's home to place of employment is unreasonable, considering the expected wage and the time and cost of commuting;

the daily commuting time exceeds two hours per day, not including the time required for transportation to a child care facility;

the distance to the place of employment prohibits walking, and public or private transportation is not available to transport the individual to the job site; or

the working hours or nature of the employment interfere with the member's religious observances, convictions, or beliefs.

2438.45.15 Work Registration And IMPACT Penalties (F, I)

Penalties for noncompliance with work registration and IMPACT are only imposed on individuals who are mandatory for work registration and/or IMPACT. (Persons who are exempt from work registration due to employment of more than 30 hours per week are subject to disqualification for voluntary quitting or reducing hours worked to less than 30.) The penalty is disqualification of the individual only. No penalty is imposed on persons exempt from work registration or voluntarily participating in IMPACT.

Individuals between the ages of 16 and 60, unless otherwise exempt, who fail to comply with Work Registration, IMPACT and work (Voluntarily Quit/Reduction) requirements will be disqualified as follows:

First Violation:

The later of the date they comply or 2 months.

Second Violation:

The later of the date they comply or 6 months.

Third or Subsequent Violations:

The later of the date they comply or 36 months.

The mandatory minimum disqualification periods (2, 6 or 36 months) are based on the number of the violation. If a disqualified participant becomes exempt from work registration the sanction is terminated immediately. The minimum disqualification period will not be served in this situation.

The disqualification begin date and violation number is displayed on ICES screen AEOIE.

When the individual complies and ends the disqualification, he is added back into the AG the month following compliance.

A one member AG may reapply following the compliance.

2438.45.15.05 Failure To Comply By An AG Member (F, I)

A nonexempt AG member, who refuses or fails without good cause to comply with work registration or IMPACT requirements, will be ineligible. Ineligibility will be for a minimum of two months, until the member complies with the requirement, or becomes exempt from work registration. The minimum penalty period depends on whether the non-compliance is the first, second or third violation (see Section 2438.45.15). If any of the criteria for ending the disqualification are met while the case is closed the sanction will be terminated when the client reapplies.

2438.45.15.10 Failure To Comply By Cash Assistance Groups (F, I)

When a Cash AG member, who also receives FS, is exempt from work registration due to TANF IMPACT Referral (Code 20 on screen AEIWP), fails to comply with an IMPACT requirement, that member will be sanctioned for both programs if they are on TANF.

If the TANF Sanction is cured, the FS Sanction will end at the same time.

NOTE: Code 20 should only be used for Food Stamp work registration when no other exemption code is applicable.

2438.45.15.15 Failure To Comply By Volunteers (F)

A volunteer who does not comply with an E & T component requirement without good cause shall not be allowed to participate in any component until the next recertification. No financial penalty is imposed for a volunteer who does not comply.

2438.45.15.20 Failure To Comply By Workforce Development Registrant (F, I)

If an FS AG member, who is exempt from work registration because he is work registered with the Department of Workforce Development, is sanctioned by that agency for failure to comply with DWD's regulations, he is considered to have failed to meet a FS requirement. If the Department of Workforce Development requirements do not exceed FS IMPACT requirements and the individual does not meet another work registration exemption, he will be subject to the appropriate FS sanction. The specific requirement and its comparability to Food Stamp requirements must be verified with the Department of Workforce Development and IMPACT. When the person complies he must be work registered and added to the AG.

2438.45.20 Cure For IMPACT Non-Compliance (F, I)

Once the notice of disqualification is sent, the disqualification may be avoided or ended in less than the minimum penalty period only if the AG contacts the FCC indicating the member wishes to comply, and does comply with the assignment or an alternate assignment scheduled by the IMPACT FCC before the effective date.

If the individual completes the activity or two full weeks of the activity, whichever comes first, the IMPACT FCC end dates the sanction on screen AEOIE by entering the first date of the cure period (the date the individual began the activity to cure the disqualification). This generates an alert to the FCC to run ED/BC to add the individual back into the AG the following month.

If the individual is in an AG alone and the case has been closed, the individual will need to reapply for benefits. The individual is eligible to receive benefits the month following the first day of the cure.

If this is after cut-off, the FCC must complete an auxiliary for the following month. If the date the "cure" began was before the effective date, the sanction must be deleted and benefits restored for the first month of the sanction.

2438.45.25 IMPACT Good Cause Determination (C, I)

For the ADCR, ADCU, and ADCI categories, a good cause exemption shall be granted only in the following circumstances: (f111)

> If the individual failed to comply with the self-sufficiency plan by voluntarily quitting employment, good cause reasons include:

A substantiated incident of discrimination by any employer based on age, race, sex, color, handicap, religious beliefs, national origin, political beliefs, or marital status.

Work demands or conditions that render continued employment financially unacceptable, such as working without being paid on schedule.

Leaving a job in connection with patterns of employment in which workers frequently move from one (1) employer to another, such as migrant farm labor or construction work.

The individual quit to accept a bona fide job offer, with the approval of the FCC, that would result in increased earnings or benefits.

The individual was unable to obtain or maintain necessary care for a minor child or an incapacitated adult residing in the home.

The employment site violates applicable state or federal health and safety standards.

If the individual failed to comply with the self-sufficiency plan by voluntarily reducing earnings, good cause exists if the reduction was due to the inability to obtain or maintain necessary care for a dependent minor child or an incapacitated adult residing in the home.

For instances of non-compliance with self-sufficiency plan which are not related to voluntary quit or reduction of earnings, good cause reasons are limited to the following:

The required actions were beyond the capability of the participant to perform, keeping in mind that Domestic Violence should be considered as a valid reason that the individual could not meet requirements, (see Section 2450.15.00).

The agency did not provide the services needed by the individual to perform the required actions.

2438.45.30 Employment and Training Good Cause Determination (C)

For the ADCQ category, a good cause exemption shall be granted only in the following circumstances: (f112)

The individual is incapable of performing the task on a regular basis due to a verified physical or mental impairment;

the total daily commuting time to the service or employment site exceeds two hours, not including child care transportation, unless the generally accepted community standard exceeds two hours;

child care is necessary for an E & T activity and such care is not available;

the conditions of the E & T site violate federal, state, or local health and safety standards;

assignments are discriminatory in terms of age, sex, race, creed, color, or national origin;

wages offered to the individual do not meet applicable federal minimum wage requirements or, if greater than the federal minimum wage rate, are less than the customary wages paid for that activity in the community;

the daily hours of work, or the weekly hours of work, exceed those customary to the occupation;

the position offered is vacant due to a strike, lockout, or other labor dispute;

the individual would be required to work for an employer contrary to his union membership;

the quality of training does not meet local employers' requirements; or

the employment offered interrupts an in-progress on-the-job training program or professional recertification program which was previously approved in an employability plan.

For ADCQ, the E & T contractor is responsible for determining if good cause exists. If it does not, the E & T contractor is to notify the caseworker to initiate a sanction.

2438.45.35 Non-Compliance Definition (C, I)

The following actions constitute failure to cooperate with any of the Cash Assistance provisions administered through IMPACT (f113) or E & T services:

Two missed assessment interviews;
failure to go to a job interview;
terminating employment;
refusal to accept employment;
voluntary reduction of employment hours; or

refusal to cooperate with any E & T agency whose services have been contracted through the provisions of the IMPACT program.

2438.45.35.05 Sanction For IMPACT Or E & T Non-Compliance (C, I, MED 2)

For ADCR and ADCU, it is the responsibility of the FCC to enter non-compliance information into ICES on AEIWP. This action produces an alert to the FCC to run AEABC. For ADCQ, the E & T contractor contacts the caseworker with noncompliance information. The caseworker must enter this information on AEICZ and run AEABC.

In an ADCU AG, both parents are required to comply with IMPACT. In this instance, each parent has a separate duty and obligation to comply with IMPACT, and either individual's failure can lead to a sanction. (f114a)

An exempt RCA volunteer in E & T may leave E & T at any time without a financial penalty. If the volunteer does not notify the caseworker before contacting the E & T contractor and withdrawing, then the volunteer will lose priority for services should he wish to return to the program at a later date. The worker will change TANF status from "V" to "E" on AEIWP.

2438.45.35.15 Length Of Employment and Training Sanction Periods (C)

For ADCQ, the following penalties apply:

For the first non-cooperation, the sanction remains in effect for three payment months.

For any subsequent non-cooperation, the sanction remains in effect for six payment months. (f115)

2438.45.35.20 IMPACT Sanctions (C, I)

The policy stated in this sub-section affects only the ADCR and ADCU categories of cash assistance. It applies to persons who are IMPACT mandatory.

IMPACT individuals who have failed or refused, without good cause, to:

Cooperate in developing a self-sufficiency plan;
comply with the participation requirements set forth in the self-sufficiency plan (f115a); or
comply with IMPACT requirements,

will have their AG closed. (f115b)

They also lose their individual Medicaid eligibility coverage under MA C until the non-compliant behavior ceases. The individual may remain eligible for Food Stamps and Medicaid/Hoosier Healthwise under a category other than MA C.

When an individual re-applies they must come into compliance prior to being approved; if not, they are to be denied.

When the client indicates a wish to comply, reschedule the activity(ies) previously missed, if available, or alternate activity(ies) which will lead to full participation. Once the client successfully completes the assigned activity(ies) or attends two (2) weeks, whichever is less, the non-compliant behavior will be considered to have ceased the day the client began the assigned activity(ies). If no appropriate activity is available, the non-compliant behavior is considered to have ceased the day the client agrees to participate. If the client accepts employment of 30 or more hours a week at minimum wage or greater, the non-compliant behavior will be considered to have ceased.

2438.50.00 VOLUNTARY QUIT (F, C)

Certain individuals, who have voluntarily quit a job or refused to accept an offer of employment without good cause, may be disqualified. An individual who voluntarily reduces his earnings without good cause is considered to have voluntarily quit a job. The specific program guidelines are discussed in the following sections.

For Food Stamps, voluntary quit or reduction of hours is treated as a work requirement. The disqualification periods for voluntary quit/reduction of hours are outlined in Section 2438.50.25.

2438.50.05 Situations Not Considered Voluntary Quit (F)

An Assistance Group member who quits a suitable job voluntarily is subject to the voluntary quit rules. This includes an AG member who is not going to work but who has not actually been terminated by the employer or has been terminated for failure to go to work. Quitting a job as a result of the following situations is not considered voluntary quit:

The client would have been exempt from work registration at the time of the quit for a reason other than the employment. (Reason code 20 is not considered an acceptable reason to not consider a voluntary quit because it is only used because of the TANF requirement. When code 20 is used, the member may still be sanctioned for Voluntary Quit);

Quit occurred 60 or more days prior to the application date;

Has been terminated (fired) by the employer for some reason other than non-attendance by the client;

Quit at the instigation of the employer; for instance, a situation in which the employee was told he had a choice: either quit or be fired;

Is under the age of 60 but the resignation is considered retirement by the employer;

Has obtained other employment subsequent to the quit of at least 20 hours a week, or the equivalent to the federal minimum wage times 20, or the training wage times 20 if the situation warrants the payment of a training wage;

Has had a change occur which causes the individual to lose exemption status, but does not have to be reported (for example, child turns six, individual remains exempt until recertification).

When any of the following criteria apply to the job the AG member quit, the worker does not need to make a voluntary quit determination.

Job was less than minimum wage or less than the training wage if the employment situation warranted the payment of a training wage.

Job was less than 20 hours per week.

Job was further than walking distance (one mile), and no public or private transportation was available.

Job involved a health risk for that person.

Job required illegal activity.

Job required that the AG member join, resign from or refrain from joining any legitimate labor organization to keep the job.

Job site was the location of a strike or lockout.

Job hours or responsibilities interfere with religious beliefs.

Job was self-employment.

Job was accepted of more than 20 hours per week or equivalent to federal minimum wage multiplied by 20, which subsequently either does not materialize, or results in employment of less than 20 hours a week, or less than the federal minimum wage multiplied by 20.

2438.50.10 Good Cause For Voluntary Quit (F)

Good cause for leaving employment includes the good cause provisions for declining employment found in Section 2438.45.10, and resigning from a job that does not meet the suitability criteria in Section 2438.45.10.10, regardless of whether the job was unsuitable at the time of employment or became unsuitable at a later date.

Other good cause criteria include:

Discrimination by any employer based on age, race, sex, color, handicap, religious beliefs, national origin, political beliefs, or marital status;

Work demands or conditions that render continued employment unreasonable, such as working without being paid on schedule;

Acceptance by any AG member of employment or enrollment at least half-time in any recognized school, training program, or institution of higher education, that requires an AG member to leave employment; or

Leaving a job in connection with patterns of employment in which workers frequently move from one employer to another, such as migrant farm labor or construction work. (This is good cause even if there is a time lapse between the ending and beginning date of employment.)

2438.50.15 Requirements For Voluntary Quit Disqualification (F)

The AG member will be disqualified for voluntary quit if all of the following conditions are met:

The individual quit employment within 60 days of the date of application, or any time thereafter;

the individual does not meet one of the exemptions for work registration;

employment involved work of at least 20 hours per week, or produced earnings in an amount at least equivalent to the federal minimum wage multiplied by 20 hours;

the individual is currently unemployed (that is, employed less than 20 hours per week, or receiving less than weekly earnings equivalent to the federal minimum wage multiplied by 20), including employees of federal, state, and local government who have been dismissed from employment because of participation in a strike against such government; and

the quit was without good cause.

2438.50.20 How To Make A Voluntary Quit Determination (F)

The caseworker will obtain a statement from the individual who quit or from the authorized representative as to the reason for the quit.

The caseworker must get enough information/verification from the AG to determine: first, if a quit occurred and second, the reason for the quit. Accomplish this during the application process if the AG is currently being certified, provided the processing time frames can be met. Otherwise, within two working days of receipt of a report of loss of employment, send the AG a notice requesting necessary information to determine whether good cause exists. Give the AG a deadline of 10 days to provide the information.

The caseworker will help obtain verification of the voluntary quit if the information is difficult for the AG to obtain.

Acceptable sources of verification include, but are not limited to:

The previous employer;
employee associations;
union representatives; or
grievances committees or organizations.

The caseworker is responsible for obtaining verification from collateral contacts provided by the AG.

If the quit resulted from circumstances that for good reason cannot be verified, such as a resignation from employment due to discrimination, unreasonable demands by any employer, or because the employer cannot be located, the AG will not be disqualified for voluntary quit.

2438.50.25 Disqualification For Voluntary Quit (F)

If a determination is made that the AG member quit employment without good cause, worker enters the information on AEIEI. When EDBC runs, the disqualification will be shown on AECES/AEIED for the individual and the reason code

will appear on AEWAA. The sanction will be displayed on AEIWP and AEACC after EDBC is run. The sanction will not be written or displayed on AEOIE until after authorization. The disqualification period will be applied as follows:

> For applicant AGs, if the quit occurred during the 60 days immediately proceeding the application date the member is disqualified for a minimum of 2 months, beginning with the day after the quit or until the AG member complies; whichever is later (for the first violation);
>
> (There is no penalty for a voluntary quit that occurred more than 60 days before the application date);
>
> for applicant AGs, if the quit occurred after the application date but prior to authorization, the AG member is disqualified for a minimum of 2 months beginning with the application date, or until the member complies; whichever is later (for the first offense);
>
> for recipient AGs, the AG member is disqualified for a minimum of 2 months, beginning with the first of the month after normal procedures for adverse action have been followed or until the member complies; whichever is later (for the first offense); and
>
> if the quit occurred in the last month of a certification period, the AG member is disqualified beginning with the first day of the month following the end of the certification period. The disqualification will last for a minimum of 2 months or until the member complies; whichever is later (for the first offense).

When the individual cures the sanction, he will be added back into the AG the month following the cure or the end of minimum sanction period, whichever is later.

A one member AG must reapply following compliance.

If an appeal is filed and continued benefits are provided pending a hearing, the disqualification cannot be imposed until the month after the hearing decision sustaining the original action is released. No claim is necessary for the benefits received pending the hearing.

When the sanction is imposed, the AG must be given a notice of denial for applicant AG members and a notice of termination for recipient AG members. The AG will be informed of its hearing rights on the notice. The notice will contain the period of disqualification and explain what the AG member may do to avoid or end the disqualification.

The penalties for subsequent offenses are the later of 6 months for the second violation and 36 months disqualification for the third violation or until the individual complies. Refer to Section 2438.45.15. If a disqualified client becomes exempt from work registration the voluntary quit sanction is terminated immediately. The minimum disqualification period may not be served in this situation.

2438.50.25.05 Disqualification For Reducing Hours (F)

Mandatory individuals who voluntarily reduce their employment to less than 30 hours a week without good cause will be disqualified according to the penalties listed in Section 2438.45.15.

Good cause will be the same good cause as for voluntary quit which is included in Sections 2438.45.10, 2438.45.10.10 and 2438.50.10. Follow the steps in Section 2438.50.20 for voluntary quit, when determining if a voluntary reduction has occurred.

2438.50.25.10 Ending A Voluntary Quit/Reduction Disqualification (F)

Individuals who have been disqualified for voluntary quit/reduction may again be certified for FS:

> When the AG member who was disqualified obtains employment comparable in salary or hours to the job that was quit/reduced and serves minimum sanction period or becomes exempt from work registration.

If any of the criteria for ending the voluntary quit/reduction are met while the case is closed the sanction will be terminated when the client reapplies.

To end the voluntary quit disqualification the worker must change the AEIWP screen then enter the end date on AEOIE.

2438.50.30 Voluntary Quit And Refusal Of Employment (C)

The voluntary quit and refusal of employment determinations for Cash Assistance depends on the assistance category and the Welfare Reform Demonstration Group to which the assistance group was assigned. The caseworker ensures that voluntary quit situations are identified and dealt with appropriately by the use of effective interviewing techniques and collateral information from employers. A voluntary quit determination may often be generated by the individual's response to an open-ended question: "How and why did your last job end?" The response to this question may prompt a collateral contact with the employer for clarification and/or verification.

The rules, penalties, and categories of assistance involved are discussed in the following sections.

2438.50.30.05 Unemployed Parent Refusals Of Employment Or Training (C)

For ADCU only, the parent who is the primary wage earner, as indicated on AEIUP, must not have refused, without good cause, a bona fide offer of employment or training for employment within the 30 days prior to the effective date of assistance. To be considered bona fide, the offer must meet applicable minimum wage requirements and wage standards which are customary for such work in the community. Good cause for refusing an offer is limited to:

The parent's physical limitations result in an inability to engage in the work;

no transportation to or from the work;

unsafe working conditions;

the employment is not covered by workman's compensation protection; or

the employment was offered through a public employment or manpower agency which determined good cause existed. (f116)

If the unemployed parent has refused without good cause, the family is ineligible for cash assistance under the ADCU category. Information is entered on AEIUP and AEIEI. This determination is made by the caseworker and must be documented on CLRC (Running Record Comments).

2438.50.30.15 Refugee Voluntary Quit And Employment Refusal (C)

For ADCQ only, an applicant may not, without good cause, voluntarily quit employment or have refused to accept an appropriate offer of employment within 30 days prior to the date of application. A recipient may not voluntarily quit a job without good cause.

The good cause determination is discussed in Section 2436.40.25.

If the applicant or recipient voluntarily quits or refuses employment, he is sanctioned in accordance with Section 2436.40.30.05.

2438.50.30.20 Voluntary Quit Or Reduction Of Hours (C)

The policy stated in this section applies only to members of ADCR and ADCU assistance groups.

An individual who has, without good cause, voluntarily quit a job or reduced hours of employment of a job of twenty (20) hours or more per week during the six (6) month period immediately preceding the date of application or at any time thereafter shall be subject to the following penalties:

> For any applicant or recipient whose needs and income are considered in determining eligibility and who quits or reduces employment, a fiscal penalty will be imposed. The TANF cash benefit will be calculated without consideration of the needs of that individual in the grant calculation for a period of six (6) months from the date of quit.(f118a) Medicaid eligibility remains available for the individual.

Please note: If an individual loses employment for reasons over which he/she has no control, such as documented illness or consistent threat of violence or harassment from a spouse or significant other, it would not be considered to be a voluntary quit.

As used in this section, "good cause" means any of the following:

1. A substantiated incident of discrimination by any employer based on age, race, sex, color, handicap, religious beliefs, national origin, political beliefs, or marital status.

2. Work demand or conditions that render continued employment financially unacceptable, such as working without being paid on schedule.

3. Leaving a job in connection with patterns of employment in which workers frequently move from one (1) employer to another, such as migrant farm labor or construction work.

4. The individual quit to accept a bona fide job offer, with the approval of the caseworker that would result in increased earnings or benefits.

5. The individual was unable to obtain or maintain necessary care for a dependent minor child or an incapacitated adult residing in the home.

6. The employment site violates applicable state or federal health and safety standards.(f118b)

2438.60.00 REGISTRATION WITH WORKFORCE DEVELOPMENT (C)

At the time of application and at all subsequent redeterminations, an electronic interface between the Department of Workforce Development and ICES will accomplish work registration for all able-bodied individuals aged 18 and over who are applying for or receiving TANF benefits for themselves and their dependent children.(f118b) The registration is automatic and requires no initial action on the part of the registrant. The eligibility worker must, however, inform the applicant/recipient during the eligibility interview that the registration will occur. Please note: If an AG includes more than one participating adult, there will be more than one registrant. Non-parent caretaker relatives who are not requesting or receiving TANF benefits for themselves will not be included in the interface.

2439.00.00 COOPERATION WITH PUBIC SERVICE REQUIREMENTS (C)

The policy in this section affects the ADCU, and ADCR categories.

An individual who is 18 years of age or less than 18 and the parent of a dependent child may be required to engage in public service in exchange for assistance under these programs. (f118c)

2439.05.00 PENALTIES FOR REFUSAL TO PARTICIPATE IN PUBLIC SERVICE (C)

The policy in this section affects the ADCU and ADCR categories.

If the individual is an applicant, then benefits are to be denied.

If the individual is a recipient, then benefits are to be discontinued. (f118d)

2440.00.00 COOPERATION WITH QUALITY CONTROL (F)

Any individual who refuses to cooperate with Quality Control's (QC) investigation may be assessed a penalty by QC. The individual cannot be certified for Food Stamps within the QC non-cooperation penalty period indicated on the QC referral, unless the AG cooperates before the end of the QC review period. If the individual cooperates, the Local Office will be notified by QC. QC non-cooperation results in the ineligibility of the entire AG. The Local Office will be notified by QC of this non-cooperation. The worker will enter the information on AEOIE, run AEABC and authorize the case.

2442.00.00 INTENTIONAL PROGRAM VIOLATION (F)

Any person whom a court or Administrative Law Judge has officially determined to have committed an Intentional Program Violation (IPV), cannot be certified for Food Stamps within the penalty period of disqualification. If a person is still within the penalty period, he is not counted in the AG size, but all of his income and expenses count.

For claim calculation and recovery information, see Section 4600.

2444.00.00 PRIORITY CHILD CARE REFERRALS (C)

TANF recipients or former TANF recipients transitioning off assistance due to earnings may be referred to the county voucher agent for priority child care services provided that they meet the non-financial criteria listed in the succeeding sections.

A referral for priority child care services is to include the names and social security numbers of the parent/caretakers, children, and any other dependent children in the TANF assistance group. The referral should also include the RID numbers for those listed above. The parent/caretakers' employment or IMPACT activity should also be listed on the referral. It is recommended that workers attach a copy of ICES screen IQCM with the TANF assistance group members highlighted to the referral. This will ensure that the voucher receives the correct RID's and SSN's. However, services should never be delayed or denied pending the collection of data and/or preparation of referral documents.

When child care is needed for the individual to participate in IMPACT employment and training activities, the family case coordinator is responsible for providing the assistance necessary to help locate quality child care services. Assistance would include, but is not limited to, the following:

Referral to the voucher agent when a qualified child care expense exists;

exploring the availability of non-traditional child care placement such as arranging child care at no cost with another TANF recipient who wishes to pursue a career in child care; and

any intervention necessary to avoid a breakdown in child care arrangements.

2444.05.00 CHILD CARE FOR TRANSITIONING OFF OF TANF (C)

Child care assistance through the voucher agent is available for a 12 month period for a caretaker in a previously eligible TANF AG to accept or maintain employment if the caretaker was a participating TANF AG member. To qualify for a referral to the voucher agent, the family must:

Have been denied or discontinued from TANF due to new or increased earnings of a participating AG member, or as a result of the expiration of the $30 and 1/3 or $30 disregards; or

have been denied or discontinued from TANF due to the earnings of a sanctioned parent/caretaker or sibling which are deemed available to the assistance group; or

have been denied or discontinued from ADCU due to the primary wage earner becoming employed 100 hours a month or more (Control Group only); or

have been discontinued from TANF due to the end of the 60 or 24-month time limits (Treatment Group only); and

have received TANF in three of the six months prior to the date on which TANF eligibility was lost.

In determining whether the family meets the three of six month requirement, months of assistance in another state are counted. However, the family must have received TANF in Indiana in at least one of the three months. A declaration by the former recipient may be used in determining a family's prior receipt of TANF in another state.

2444.05.05 Child Care For TANF Recipients (C)

Current TANF recipients may be referred to the county voucher agent for priority child care services as long as the child care is necessary to permit the recipient to participate in employment or IMPACT approved educational or training activities that are part of the individual's self-sufficiency plan. A priority referral should not be given if the TANF client is pursuing educational or training activities outside of IMPACT. Caretaker relatives who are not participants in the assistance group due to IMPACT, IV-D, or IPV sanctions or due to the 24-month clock are considered TANF recipients for purposes of a priority referral. Non-participating non-parent caretakers (aunts, uncles, grandparents, etc.) and parents receiving SSI are NOT TANF recipients and thus not eligible for a priority referral. If the non-parent caretaker is a TANF recipient, a priority referral may be made if he meets the criteria listed above.

2444.05.10 Non-Priority Child Care Referrals

Step Ahead voucher agents give current TANF recipients top priority for child care services. Voucher agents have been trained to process anyone referred by the local office with a TANF referral as a priority. Local offices may refer families who do not receive TANF or TANF recipients working outside of IMPACT to their voucher agents but must use a different referral form or clearly note on the referral that this person is not a priority referral. Local offices must coordinate with their voucher agents to develop a procedure for referring these non-priority families. Families referred in this way will be treated as any other non-TANF family requesting child care assistance and will not receive any special consideration by the voucher agent.

2446.00.00 STRIKE PARTICIPATION (C)

Within the C category, the policy stated in this section only applies to ADCU, ADCR, and ADCI.

A strike is defined as a concerted failure to report for duty, willful absence from one's position, stoppage of work, or abstinence in whole or in part from the full, faithful, and proper performance of the duties of employment, without the lawful approval of the employer, or in any concerted manner interfering with the operation of an employer. (f138)

Participating in a strike is engaging in any activity or lack of activity included in the above definition of "strike". (f139)

An employee who terminates employment with a striking company, or is fired, is not considered to be participating in a strike.

2446.05.00 INELIGIBILITY DUE TO STRIKE PARTICIPATION (C)

Within the C category, the policy in this section only applies to ADCU, ADCR, and ADCI.

An AG is ineligible for TANF for any payment month in which the natural or adoptive parent residing in the home (regardless of whether the parent is included in the award), or the only eligible child, is participating in a strike on the last day of the month. (f140) If any other participating member of the AG is on strike on the last day of the month, he is ineligible for TANF and his needs are not to be included when determining eligibility for the remainder of the AG. (f141)

EXAMPLE: AG receives TANF check on 9/1. Parent/caretaker goes on strike 9/15 and continues on strike through the end of the month. The AG is not eligible for the September check and recoupment should be pursued.

2448.00.0 (RESERVED)

2450.00.00 PERSONAL RESPONSIBILITY AGREEMENT (C)

The policy in this section affects only the ADCU and ADCR categories of cash assistance.

The Personal Responsibility Agreement (PRA) represents a partnership between the Division and the parent or caretaker committed to the goal of economic independence for the client. The PRA is a vehicle for the recipient to declare his understanding of the program expectations and consequences for non-compliance as well as affirm his willingness to comply with the requirements. (f144) By signing the PRA, a parent/caretaker relative specifically agrees, that as a recipient of cash benefits, he/she will:

Ensure that the children under his care and control receive all age-appropriate immunizations as recommended by the American Academy of Pediatrics;

ensure that the school-aged children under his care and control are in compliance with the school district's attendance standards;

ensure that children under his care and control are raised in a safe, secure home;

if he is a minor parent, live in the home of a supervisory adult;

ensure that he/she does not use illegal drugs or abuse other substances that would interfere with his/her ability to be self-sufficient;

cooperate with the IMPACT worker in developing a self-sufficiency plan.

The client's signature on the PRA also indicates that he has been informed of the following penalties and is aware of the actions likely to cause the penalties to be imposed:

Temporary Assistance for Needy Families (TANF) cash benefits will not increase for the addition of a child born more than ten calendar months after the initial effective date of TANF benefits or June 1, 1995, whichever date is later;

the imposition of program fiscal penalty against recipients who voluntarily terminate employment while receiving TANF or during the six (6) month period immediately preceding the date of application for TANF;

the disqualification from TANF of individuals found to have committed intentional violations of the TANF Program (IPV's);

the imposition of program sanctions against individuals who refuse or fail to cooperate in developing a self-sufficiency plan or to comply with the requirements of an already established plan;

the 24-month time-limitation placed on the receipt of cash benefits by individuals who are mandatory employment and training participants; and

the reduction of TANF benefits to the assistance groups of recipients who fail or refuse (without good cause) to sign the Personal Responsibility Agreement.

All TANF recipient parents and TANF recipient non-parent caretakers are required to sign the Personal Responsibility Agreement. This includes minor parents as well as adults. When the participating assistance group includes two parents (this would be ADCU, ADCI or an ADCR assistance group which includes an adult recipient parent and a recipient minor parent) both parents must sign an agreement.

The following individuals may be asked to sign the PRA but suffer no penalties for failure to sign the agreement or comply with program requirements:

Non-recipient non-parent caretakers of TANF recipient children;

non-recipient supervisory adults with whom minor parents are living;

parents and other caretaker relatives who are SSI recipients;

parents and other caretaker relatives who are under IV-D or IMPACT sanction; and

parents who are TANF-ineligible aliens.

At the authorization of TANF eligibility (whether as a result of a new application or a reapplication for benefits which were previously discontinued) the Personal Responsibility Agreement is to be discussed and signed in the presence of a caseworker, who also signs it. The adult recipient's signature should be obtained as soon as the individual's eligibility status is determined. If an individual who is required to sign a PRA is not present at authorization, his/her signature must be obtained within thirty days of authorization.

The parents and/or other recipient caretakers are to be contacted to:

Inform them of the requirement to sign the Personal Responsibility Agreement;

provide instructions for contacting the caseworker to sign the Personal Responsibility Agreement;

establish a deadline date for contacting the caseworker to schedule an appointment; (This due date should be no fewer than ten days from the mailing date of the notice.)

discuss the penalty for failing, without good cause, to sign the Personal Responsibility Agreement by the deadline date.

A recipient parent/caretaker who joins an active assistance group would be required to sign the Personal Responsibility Agreement at the interview, or within 30 days.

NOTE: If the Personal Responsibility Agreement requirement is presented during the redetermination process, it is not actually a part of the redetermination and would not (if unmet) result in the discontinuance of TANF benefits. The penalty for failure, without good cause, to sign the Personal Responsibility Agreement is a $90 fiscal penalty (per non-compliant individual) whether the requirement is presented at initial eligibility, at redetermination point, or because of a change in the family's circumstances.

Changes which would necessitate presenting the PRA requirement prior to a redetermination include:

The addition of a recipient parent or other caretaker relative to an assistance group;

the inclusion of a former SSI-recipient parent/caretaker relative as a participating member in an AG following the loss of SSI eligibility; and

the birth of a child to a minor who is receiving assistance.

The notification requirements for these situations are identical to those outlined for imposing the Personal Responsibility Agreement requirement after initial authorization.

Refusal or failure (without good cause) to sign the Personal Responsibility Agreement within the designated time period results in a reduction of the TANF grant in the amount of $90 per non-compliant recipient adult. The non-compliant parent/caretaker relative continues to be an eligible TANF recipient and is:

Subject to TANF IMPACT requirements;

entitled to receive supportive services if participating in employment and training activities;

entitled to be referred for child care assistance, if otherwise eligible;

eligible for Medicaid as a TANF recipient.

The penalty will be invoked throughout the length of the non-compliance and is lifted when the recipient:

Signs the Personal Responsibility Agreement;

has shown good cause for failure to sign; or

timely appeals the Personal Responsibility Agreement fiscal penalty. The fiscal penalty is removed until the issue is resolved through the fair hearing process.

If the recipient comes into compliance before the effective date of the fiscal penalty, the penalty is not to be imposed. When compliance occurs after cut-off, the following month's reduced benefits must be augmented with an auxiliary payment to remove the penalty.

A recipient caretaker relative will be considered to have "good cause" for refusing or failing to sign the Personal Responsibility Agreement only if determined to be mentally incompetent and incapable of understanding the requirements of the Personal Responsibility Agreement by a licensed physician or a licensed mental health professional. If verification of mental incompetence has been obtained, the caseworker enters good cause reason (01) on AEWRT to prevent a fiscal penalty.

Since there is only one condition of good cause, every attempt should be made to assist clients who are willing,

but unable (due to circumstances beyond their control) to sign the Personal Responsibility Agreement in a timely manner. This is particularly important given the necessity of signing in the presence of a caseworker. In certain circumstances, such as illness, incapacity, and unavailable transportation, it will be necessary to visit the home or hospital to obtain the recipient's signature.

2450.05.00 THE REQUIREMENT TO COMPLY WITH SCHOOL ATTENDANCE POLICY (C)

The policy stated in this section affects only the ADCR and ADCU categories of cash assistance.

If a TANF recipient child aged seven through seventeen has more than three (3) unexcused absences as defined by the school district during a semester or grading period, his/her recipient caretaker relative is required to comply with a written improvement plan, developed by the school or by the Local Office in conjunction with the caretaker relative. (f142)

The provision applies to all school-aged children except those who are:

Not part of the TANF assistance group due to their receipt of SSI;

Excluded from the assistance group because they are ineligible for TANF;

Children in the care of relatives who are not included in the TANF award;

Children whose parents are excluded from the TANF assistance group due to the receipt of SSI (Note: This would not apply if both of the child's parents were in the home and one of the parents did not receive SSI.);

Children whose parents are under IV-D or IMPACT sanction.

Note: Children who are excluded from the TANF payment calculation because of the family benefit cap provision are nevertheless considered to have TANF eligible status. Therefore, their recipient caretaker relatives are required to cooperate with an improvement plan should their attendance be at an unacceptable level.

The procedure used to verify the number of unexcused absences will depend upon the arrangement established between the Local Office and each school system to provide notification of all children whose attendance is

unacceptable. The Local Office is to investigate only when the school reports that there is a problem.

When a child has been identified as having more than three (3) unexcused absences, the circumstances must be evaluated to determine the reasons for the unexcused absences. The caseworker should accomplish this by discussing the attendance problem with:

School personnel;
The parent; and/or
The child

Once causative factors have been identified, they should be documented on the Running Record Comments Screen (CLRC). Any hard copy material pertaining to the reasons for the child's absenteeism should be maintained in the case file.

After the reasons for excessive absenteeism have been determined and documented, a written plan of action will be developed with the parent. If the school has a plan in place, the Local Office need not devise another. The plan should explain specific barriers to school attendance and specific measures to be taken by the parent to remove them. It is necessary that the plan be developed as a collaborative effort between the caseworker and the recipient caretaker. By working with the caseworker, the recipient caretaker is more likely to gain a clear understanding of what is expected and the consequences of failure to fulfill his/her part of the agreement.

A parent or other recipient caretaker is considered to be in compliance with the school attendance requirement unless he/she refuses or fails (without good cause) to:

- Cooperate in developing a written plan, or

- perform the specific activities included in the written plan, or

- consent to release the school attendance information when such consent is required to obtain school attendance information.

A parent or caretaker relative may be penalized immediately after failing or refusing to cooperate with the treatment plan after the child has three (3) unexcused absences. Refusal or failure to comply with a treatment plan can occur at any time and as early as at the time of plan development. The child may only be penalized if he/she has three or more unexcused absences in a subsequent grading period or semester. Therefore, if, his attendance is acceptable in a subsequent semester or grading period, there is no parental non-compliance, even if the adult ceases or fails

to follow the improvement plan. Conversely, the caretaker relative is considered to be in compliance as long as he is following the improvement plan, whether the child's attendance improves or not.

The monitoring of the adult recipient's cooperation with the improvement plan will involve obtaining verification (no less frequently than at each subsequent redetermination of TANF eligibility) that each specific required action in the plan is being taken.

A penalty for non-compliance is not to be imposed without verification that the recipient caretaker relative failed or refused (without good cause) to perform the specified, mutually agreed-upon activities included in the school attendance improvement plan.

If the parent or caretaker relative is in compliance but the child continues to have unexcused absences in any subsequent grading period, the grant will be reduced by an amount equal to removing the child's needs from the grant determination. The earliest a penalty against a child can occur is a subsequent grading period. Penalties against a child last until the end of the grading period and start again with the fourth unexcused absence in the following grading period.

If the parent or caretaker relative fails or refuses to cooperate in the attendance improvement plan and the child does not meet the attendance standard in a subsequent semester or grading period, the TANF benefit amount will be reduced by an amount equal to removing the needs of the parent or caretaker relative and the child. In a two-parent TANF assistance group, both parents must assist in developing and complying with the plan. If one parent is non-compliant without good cause, the TANF benefit is reduced by an amount equal to removing his/her and the child's needs. If both parents are out of compliance without good cause, the grant is reduced by an amount equal to removing both parents and the child's needs from the grant determination. Penalties against parent/caretaker relatives last until compliance or the child's attendance is satisfactory which ever is earliest. Penalties against a child last until the end of the grading period.

The non-compliance penalty is a fiscal penalty assessed against the TANF payment of the assistance group and is not to be confused with an ineligibility sanction (IV-D or IMPACT) which is applied to individuals. In an assistance group under the fiscal penalty, all assistance group members (including the non-compliant adult) continue to be TANF recipients and are:

Subject to TANF IMPACT requirements;

Eligible to receive supportive services if participating in employment and training activities; and

Eligible for Medicaid as TANF recipients.

Because school systems vary so much when their grading periods or semesters start and stop, ICES will not be able to track when the non-compliance penalties end. It is up to the Local Offices to contact the school systems for this information.

ICES uses the information entered on AEWRT in determining whether to apply the fiscal penalty. It is, therefore, essential to review the screen prior to imposing a penalty to ensure that the individual is actually subject to the requirement. Non-recipient caretaker relatives such as sanctioned parents, parents who are ineligible aliens and non-parent caretaker relatives who have opted not to receive TANF are not subject to the school attendance requirement. Therefore, no penalty can be assessed on their assistance groups for their failure to comply with a plan to improve attendance.

If the caretaker relative comes into compliance prior to the effective date of the fiscal penalty, it is not to be imposed.

A recipient caretaker relative is considered to have good cause for non-compliance with the written plan of the school or the Local Office if:

The child is suspended or expelled for behavior problems and the school has verified that no alternative educational situation exists. For good cause to exist, the recipient caretaker relative would have to be in compliance with a plan established by a treatment professional who is monitoring the situation;

The child has a mental or physical condition as determined by a licensed health care professional, that prohibits the child from integrating into the normal school environment and there is no alternative educational situation;

The actions required in the improvement plan were beyond the capability of the recipient caretaker relative; or

The division did not provide the services needed by the recipient caretaker relative to perform the required actions.

Screen (AEWRT) includes a space to code the reason for a failure to comply with the written plan. The codes for school attendance "good cause" are to be entered there and may be found in Table RFDI/TASR.

Compliance exists and no penalty is imposed on the parent or caretaker relative if he/she cooperates with the written improvement plan.

A minor parent is not subject to the school attendance provision unless he/she must (according to traditional TANF rules) assume the role of a dependent child in an assistance group which includes the minor's applicant or recipient sibling(s) and his parent or caretaker relative. If the minor parent heads his/her own assistance group, the school attendance provision does not apply. A minor parent living in the home of a supervisory adult (see IPPM 3215.05.25.05) for the TANF benefit is still considered to be the head of his/her assistance group.

2450.10.00 THE IMMUNIZATION REQUIREMENT (C)

The policy stated in this section affects only the ADCR and ADCU categories of cash assistance.

TANF recipient parent/caretakers must provide verification that all children for whom they receive TANF benefits have received all standard childhood immunizations appropriate to their age level. (Note: Although recommended by the Indiana State Department of Health, Hepatitis B vaccine has not been readily available and is, therefore, not required for TANF recipient children.) Documentation that the immunization requirement is met must be provided as follows: (f143)

At the next scheduled redetermination following initial eligibility; and

At each subsequent redetermination of eligibility.

Immunizations are required for school attendance. Therefore, a school-aged child who is currently enrolled may be presumed to be immunized or to have been excused from the requirement (by his school system) for good cause. In either case, the child would meet the TANF immunization requirement. Verification would be limited to information confirming the child's enrollment.

Medical documentation is necessary if the child is under school-age or receives "alternative" schooling.

If the recipient parent/caretaker provides clear medical documentation that the child has received all age-appropriate immunizations, the requirement is met. The caseworker completes the Indiana Immunization Certificate

from the information at hand and maintains it in the case file. Recipient parents and recipient caretaker relatives who do not submit their own medical documentation are to be given the Indiana Immunization Certificate and the Indiana State Department of Health (ISDH) Immunization Record. The recipient takes these forms to the child's physician, the local health department or another immunization provider for review and signature. The signed certificate is then to be returned to the caseworker by the recipient within 10 calendar days. Upon receipt, it is to be filed and maintained in the case file. The recipient should be instructed to retain the immunization record for future use.

Children are not subject to the immunization requirement if they are:

- Not part of the TANF assistance group due to their receipt of SSI;
- Excluded from the assistance group because they are categorically ineligible for TANF;
- Not mandatory members of the assistance group and the caretaker relative did not wish to include them in the TANF award;
- Children in the care of relatives who are not included in the TANF award;
- Children whose parents are excluded from the TANF assistance group due to the receipt of SSI (NOTE: This does not apply if both of the child's parents are in the home and one of the parents does not receive SSI.);
- Children whose parents are under IV-D or IMPACT sanction.

NOTE: Children who are excluded from the TANF payment calculation because of the family benefit cap provision are, nevertheless, considered to have TANF eligible status. Therefore, their recipient caretaker relatives are required to have them immunized.

If the recipient caretaker relative of a child who is subject to the immunization requirement fails or refuses to comply, without good cause, the AG's TANF benefits are to be reduced by $90 per month until the requirement is met.

The good cause reasons for non-compliance include:

- That the recipient refuses to have the child immunized because of religious beliefs;

That the recipient has documented medical evidence from a licensed health care professional that an immunization is not appropriate for the child.

2450.15.00 THE REQUIREMENT TO RAISE CHILDREN IN A SAFE, SECURE HOME (C)

The policy stated in this section affects only the ADRC and ADCU categories of cash assistance.

Parents/caretaker relatives are required to raise the children under their care and control in a safe, secure home. As defined for this provision, a safe, secure home is one that is free of substantiated domestic violence or substantiated incidents of child abuse or neglect.(f143a)

Individuals are not subject to this provision if they are:

Not part of the TANF assistance group due to their receipt of SSI;

Excluded from the assistance group because they are categorically ineligible for TANF;

Not mandatory members of the assistance group and the caretaker relative did not wish to include them in the TANF award;

Caretaker relatives who are not mandatory members of the assistance group, and have elected not to be included in the cash award;

Caretaker relatives who are under IV-D or IMPACT sanction.

Non-compliance with this provision occurs when:

There is a substantiated incident of child abuse or neglect or domestic violence involving an AG member;

It has been determined that the parent/caretaker relative is in need of counseling or other actions to prevent further incidences; and

The parent/caretaker relative fails or refuses, without good cause, to comply with the counseling or other actions determined to be appropriate.

Good cause is considered to exist when:

The required actions were beyond the capability of the individual to perform; and

The agency did not provide the services needed by the individual to perform the required actions.

The non-compliance penalty is a $90 fiscal penalty assessed against the TANF payment of the assistance group and is not to be confused with an ineligibility sanction (IV-D or IMPACT) which is applied to individuals. A $90 per month fiscal penalty will be assessed for each member who is out of compliance. For example, in a two parent TANF assistance group, if both parents are out of compliance, the penalty will be $180. In an assistance group under the $90 fiscal penalty, all assistance group members (including the non-compliant member) continue to be TANF recipients and are:

Subject to TANF IMPACT requirements;

Eligible to receive supportive services if participating in employment and training activities; and

Eligible for Medicaid as a TANF recipient.

If compliance occurs prior to the effective date of the fiscal penalty, it is not to be imposed.

In cases of substantiated child abuse or neglect, the child welfare staff maintains responsibility for monitoring the family situation and compliance with a service plan. Consequently, each local office will need to establish procedures to notify the eligibility worker when a TANF parent/caretaker does not comply with the Child Welfare Service Plan.

In cases of domestic violence, monitoring will depend on the worker's interviewing ability and the recipient's willingness to share information. At the point where the worker has been notified of domestic violence, it will be necessarily to obtain verification that an actual substantiated case exists. The individual should be given notice that verification is required (i.e., a police report or statement from a certified counselor) and the regular change reporting/verification procedures should be followed. If no verification is obtained, no penalties will be applied.

If verification is obtained that a substantiated case of domestic violence does exist, the individual will need to provide documentation as to the recommended treatment plan. The monitoring of the individual's cooperation with the recommended plan will involve obtaining verification (no less frequently than at each subsequent redetermination of eligibility, or until that time that the service provider indicates service is no longer required) that each specific required action in the plan is being taken. The individual

is considered to be in compliance as long as he/she is following the treatment plan, whether there are further incidence of domestic violence or not.

2450.20.00 THE REQUIREMENT TO ABSTAIN FROM DRUG OR SUBSTANCE ABUSE (C)

The policy stated in this section affects only the ADCR and ADCU categories of cash assistance.

Recipient parent/caretaker relatives are prohibited from using illegal drugs or abusing other substances that would interfere with their ability to be self-sufficient..(f143b)

Individuals are not subject to this provision if they are:

Not part of the TANF assistance group due to their receipt of SSI;

Not an adult required to sign a Personal Responsibility Agreement (PRA);

Excluded from the assistance group because they are categorically ineligible for TANF;

Not mandatory members of the assistance group and the caretaker relative did not wish to include them in the TANF award;

Caretaker relatives who are not mandatory members of the assistance group, and have elected not to be included in the cash award; and

Caretaker relatives that are under IV-D or IMPACT sanction.

Once an individual has been found out of compliance with this provision, the individual is to be referred to a state approved alcohol and drug addiction service provider for assessment and treatment recommendation. If the individual fails or refuses, without good cause, to comply with the assessment or recommended treatment, it will result in the imposition of a $90 fiscal penalty per month for each individual assessed against the assistance group. For example, in a two-parent TANF assistance group, if both parents are out of compliance, the penalty will be $180. In an assistance group under the $90 fiscal penalty, all assistance group members (including the non-compliant member) continue to be TANF recipients and are:

Subject to TANF IMPACT requirements; and

Eligible to receive supportive services if participating in employment and training activities.

Good cause for purposes of this requirement is defined as:

> The required actions were beyond the capability of the individual to perform; and
>
> The agency or addiction service provider did not provide the services needed by the individual to perform the required actions.

If compliance occurs prior to the effective date of the fiscal penalty, the penalty is not to be imposed.

An individual should not be referred to a service provider for treatment unless there is substantiated or documented evidence that he/she is using illegal drugs or abusing other substances that would interfere with their ability to be self-sufficient, for example:

> The recipient admits to using illegal drugs or abusing other substances or has a drug related conviction; and
>
> The recipient is referred for a job and fails the drug screening or is fired from a job for failing a drug screening.

When a questionable situation arises, keep in mind that you would not make a referral unless the evidence would be such that it could be used in a legal action. We do not act on suspicions.

The individual who has been determined to be out of compliance with this provision should be referred to a state approved alcohol and drug addiction service provider. For purposes of this provision, a state approved provider is defined as:

> A provider who offers a broad range of planned and continuing care, treatment, and rehabilitation, including, but not limited to, counseling, psychological, medical, and social service care designed to influence the behavior of individual alcohol abusers, or drug abusers based on an individual treatment plan; and has regular certification or outpatient certification.

The individual should be instructed to provide verification from the provider that he/she is receiving services. Any hard copy verification should be maintained in the case file. Accompanying documentation should be made in the running record comments (CLRC). Monitoring of compliance with the treatment plan should occur no less frequently than at each subsequent redetermination of eligibility, or until that time when the service provider indicates service is no

longer required. The individual is considered to be in compliance as long as he/she has submitted for an assessment and is following the treatment plan, whether there are further abuses of the substances or not.

2452.00.00 TANF 60 MONTH BENEFIT LIMIT (C)

The policy, stated in this sub-section, affects only the ADCR and ADCU categories of cash assistance.

Effective 04/01/02 (10/01/06 for ADCU), assistance groups that include a parent or caretaker relative, are subject to a 60-month lifetime limit on cash assistance. (f146)

The 60-month limit is separate and distinct from the 24-month limit discussed in the following section.

Only months where a parent or caretaker relative is receiving TANF cash assistance in the AG will count in the 60-month limit clock. Once an individual has reached the 60-month limit, the household is prohibited from receiving TANF for the lifetime of the individual while he remains in the AG.

The 60-month clock does not apply to children independently; children are only affected by the limit based on the parent or caretaker relative in their AG who is subject to the limit.

Only months starting with April 1, 2002 will count toward the 60 months. For ADCU, only months starting with October 1, 2006 would be included in the count, unless they had previously been in ADCI.

The 60-month limit results in ineligibility for the parent/caretaker as well as the children included in the assistance group while the 24-month period affects only the parent or caretaker.

2452.05.00 OUT OF STATE TANF AND THE 60 MONTH LIMIT (C)

The policy in this section affects ADCU and ADCR categories.

When an individual applies for TANF cash assistance, they should be asked for all addresses/states where they or any other member of their immediate family have lived for the previous three (3) years, and the caseworker should then contact any other states provided to determine whether they received assistance that would count against their 60 month benefit level. (f151)

2452.10.00 OUT OF STATE 60 MONTH LIMIT PENALTIES (C)

The policy in this section affects both the ADCU and ADCR

categories.

If an individual refuses or fails to provide the department with the information required, the TANF benefit is to be denied. (f152)

2453.00.00 24 MONTH BENEFIT LIMIT (C)

The receipt of cash assistance is limited to twenty-four (24) months for adults in the ADCR and ADCU categories of assistance who are mandatory for IMPACT. (f146a) Any assistance months an adult was subject to the time limits prior to 6/1/97 (Placement Track) is counted towards the 24-month time limit. **Effective 6/1/97**, only months that the adult received assistance or is considered a recipient due to a zero-grant status, count towards the time limit with the exception of months that the adult was sanctioned. Months that an adult was sanctioned by either IV-D or IMPACT count towards the 24-month time limit.

At application, the 24-month clock will start with the effective date of the first month's TANF benefits for IMPACT mandatory adults. For on-going cases when an exempt adult becomes IMPACT mandatory, the 24-month clock starts with the next possible month allowed by adverse action. When adding an IMPACT mandatory adult to an on-going case, the 24-month clock starts with the first month the adult’s needs are considered in the grant. (Note: when an IMPACT mandatory minor parent caretaker turns 18, both the IMPACT and eligibility worker will receive alert. The eligibility worker initiates the 24-month clock by running AEABC and authorizing the TANF assistance group. The clock will start with the next possible month allowed by adverse action.)

Upon expiration of the 24-month period, an individual who has cooperated with program requirements and with the self-sufficiency plan (see Section 2456.20.00) may receive an extension under the following circumstances:

- The division substantially failed to provide the services specified in the individual's self-sufficiency plan.

- Despite all appropriate efforts, at or after the time limit, the individual has been unable to find, or has lost without cause, employment that in combination with other income would provide the AG with income at least equal to the TANF grant plus the ninety dollar ($90) work expense allowance.

The Division Director makes a determination that there are other unique circumstances beyond the control of the individual, such as the adverse effects of a natural disaster or other catastrophic event such as the individual's exposure to Domestic Violence that resulted in the individual's inability to obtain or retain employment.

In addition, recipients may earn one (1) month of TANF benefits for every six (6) consecutive months during which they were employed full time. (For employed individuals, this is defined by the employer; for self-employed individuals, it is defined as 35 hours @ minimum wage per week, which may be calculated by dividing their income by the federal minimum wage.) (f146b) Credit cannot be earned for periods of employment prior to 6/1/97, or for employment prior to the recipient's first application for TANF. A month during which an individual was ineligible for TANF due to a IV-D or IMPACT sanction is **not** considered a consecutive month of full time employment for purposes of calculating entitlement to additional months. An individual may not retain credit for more than 24 months at any one time. The individual is automatically entitled to an extension for a period equal to the number of accrued months, but only if the individual requests an extension.

Sixty (60) days prior to the end of the 24 months, the recipient will be notified of the date his/her 24 months ends. The notice will explain who qualifies for an extension and on what grounds.

RECIPIENTS MAY REQUEST AN EXTENSION AT ANY TIME BEFORE OR AFTER THEIR 24 MONTH PERIOD HAS ENDED. However, individuals who receive a 60 day advance notice are asked to return the extension request portion of the notice within 13 days of the mailing date of the notice to expedite the process. (No penalty will be taken if the recipient does not request an extension within this 13 day period.) The request must include explanation of why the recipient feels eligible for the extension and any verification he/she has that can substantiate this claim.

An extension should be for a period sufficient to allow IMPACT and the recipient to determine and remove the barriers that still exist in keeping the recipient from achieving self-sufficiency. Extensions may be for up to twelve (12) months, are renewable, and go into effect in the month following approval.

The FCC will have ten (10) days from the receipt of the extension request to review and draft a response to the recipient's request which will be submitted to the Division Director for a final decision. The response is to be

submitted with all documentation necessary to explain the recipient's situation with regard to attaining financial independence within 24 months. The response package for the Director is to include, at minimum:

A copy of the Self-Sufficiency Plan with all updates;

a detailed explanation of any barriers facing the recipient and all services provided by the Local Office to address these barriers;

a detailed explanation of the FCC's actions that were taken to assist the recipient overcome the barriers which were identified over the last two years and why those efforts were unsuccessful;

a direct response for the justification provided by the recipient to support the request if different from the barriers listed above, or;

a recommendation to the Division Director to approve or deny the request. If approval is proposed, the FCC is also to recommend the length of time (not to exceed 12 months) the recipient's benefits should be extended and provide a rationale for this recommendation.

The recipient's request and the Local Office response package are to be submitted to the Regional Manager for review and recommendation within ten (10) days of the recipient's request. The recommendation is then forwarded by the Regional Manager to Division Director for the final response to the extension request. The Division Director is responsible for the official decision to either approve or deny the request. The Director's approval or denial response is returned to the appropriate Local Office for notice and implementation.

The eligibility worker will enter the approval or denial on ICES screen AETEX. If approved, the length of the extension must be entered. If denied, the reason for the denial must be coded on AETEX and documented thoroughly on ICES screen CLRC.

Anyone may "bank" time so that months may be used at a later date if needed by withdrawing their AG from TANF or, if the individual in the time clock is an optional AG member, by having the optional person withdraw from TANF.

If the individual in the 24-month clock loses eligibility for cash benefits <u>solely</u> because the 24-month benefit period expired, the rest of the assistance group will remain eligible for a cash payment as long as the AG continues to meet all other eligibility criteria. The individual subject to the 24-month limit is still considered a recipient and as

such is eligible to receive MA C and must continue to cooperate with IMPACT and IV-D.

2454.00.00 SELF-SUFFICIENCY PLAN (C, I)

The policy stated in this sub-section affects only the ADCR, ADCI and ADCU categories of cash assistance.

The self-sufficiency plan is developed jointly by the recipient and the IMPACT worker and specifies, in writing, the activities required of the client and the services required of the agency during the 24-month period. The worker is required to initiate the development of a self-sufficiency plan within 30 days of the assignment. The recipient is allowed 10 days to comply with the requirement. The self-sufficiency plan must be reviewed with the recipient at every redetermination at minimum. (f147)

2499.00.00 FOOTNOTES FOR CHAPTER 2400

Following are the footnotes for Chapter 2400:

(f1) Social Security Act, Section 1137(d)
(f4) Social Security Act, Section 1903(v)
(f4a) HCFA Letter to State Officials, 10/6/99: Provisions On Access and Cost Sharing for American Indian/Alaska Native Children).
(f6) Social Security Act, Section 1137(a)(1)
42 CFR 457.340(b), Effective 2/1/02
(f7) 45 CFR 205.52;
42 CFR 435.910
(f8) 45 CFR 205.52
(f9) Social Security Act, Section 402 (a)(7)
(f10) 7 CFR 273.3
(f11) 45 CFR 233.40
(f12) 42 CFR 435.403
(f13) 45 CFR 233.40;
7 CFR 273.3
(f14) 42 CFR 435.403
(f15) 405 IAC 2-2-1
(f15a) 1902(a)(10)(A)(ii)(XV) and 1902(a)(10)(A)(ii)(XVI) of the Social Security Act
(f16) 405 IAC 2-2-2;
IC 12-7-2-21
(f17) 42 CFR 435.531
(f18) 42 CFR 435.531
405 IAC 2-2-2
(f19) (Social Security Act, Section 1902(a)(12);
42 CFR 435.531
(f20) IC 12-7-2-21
405 IAC 2-2-2
(f21) 42 CFR 440.270
(f22) 405 IAC 2-2-2
(f23) 470 IAC 2.1-2-1

(f24) 470 IAC 2.1-2-1
(f25) 405 IAC 2-2-2
(f26) 470 IAC 2.1-1-2
(f27) 470 IAC 2.1-1-2
(f27a) IC 12-14-15-1 as amended by P.L. 67-2000 and P.L. 218-2003
(f28) IC 12-14-15-1
470 IAC 2-9-6
(f28a) 470 IAC 2-9-7
(f29) 470 IAC 2.1-1-2
(f30) 42 CFR 440.270
(f31) 405 IAC 2-2-4
(f32) 405 IAC 2-2-4
(f33) 42 CFR 435.541;
405 IAC 2-2-3
(f34) 470 IAC 2.1-1-2
(f35) 470 IAC 2.1-1-2
(f36) Social Security Act, Section 402(a)(24);
45 CFR 233.20
(f37) Social Security Act, Section 1619(b)(3);
(f38) Social Security Act), Section 1902(a)(10)(E)
(f39) Social Security Act, Section 1905(p)(1) as amended by the Technical and Miscellaneous Revenue Act of 1988
(f40) Social Security Act, Section 1902(a)(10)(E)
(f41) Social Security Act, Section 1905(s)(4) as added by P.L. 101-239)
(f42) Section 1902(a)(10)(E)(iii)
(f42a Social Security Act, Section 1902(A)(10)(E)
(f42b Social Security Act, Section 1902(A)(10)(E)
(f43) RESERVED
(f44) RESERVED
(f45) RESERVED
(f46) RESERVED
(f47) RESERVED
(f48) RESERVED
(f49) RESERVED
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(f59) RESERVED
(f60) RESERVED
(f61) RESERVED
(f62) RESERVED
(f63) RESERVED
(f63a) RESERVED
(f64) RESERVED
(f65) Social Security Act, Section 406(a)(c)

(f66) 45 CFR 233.90
(f67) 45 CFR 233.90
(f68) 45 CFR 233.90
(f69) 45 CFR 233.90
(f70) 45 CFR 233.90
(f71) 45 CFR 233.90
(f71a) 470 IAC 10.1-2-6
(f72) 42 CFR 435.1009
(f73) 42 CFR 435.1009
(f74) 42 CFR 435.1009
(f75) 42 CFR 435.1009
2110(b)(2)(A)
(f76) 42 CFR 435.1009
(f77) Social Security Act, Section 1905(i)
(f78) 42 CFR 441.151
(f79) Social Security Act, Section 1905(n)(1)
(f80) Social Security Act, Section 1902(e)(4)
as amended by OBRA-90 (P.L. 101-508)
(f81) 42 CFR 435.222
(f82) 42 CFR 435.608
(f83) 45 CFR 400.56
(f84) 45 CFR 400.94
(f84a) Section 2110(b)(2) of the Social Security Act
(f85) Social Security Act, Section 1912(a);
42 CFR 433.145
(f86) 42 CFR 433.146
(f87) 42 CFR 433.147
(f88) 470 IAC 2.1-4-5
(f89) 470 IAC 2.1-4-6
(f90) Social Security Act, Section 1912(a);
42 CFR 433.148
(f91) 42 CFR 433.148
(f92) IC 12-1-7-1.1
(f93) IC 12-1-7-5.1
(f94) Social Security Act, Section 402(a)(26);
45 CFR 232.12
(f95) 45 CFR 232.12
(f96) Social Security Act, Section 402(a)(26);
45 CFR 232.42
(f97) 45 CFR 232.40
(f98) 45 CFR 232.46
(f99) 45 CFR 232.41
(f100) 45 CFR 232.42
(f101) 45 CFR 232.42
(f102) 45 CFR 232.42
(f103) 45 CFR 232.43
(f104) 45 CFR 232.41
(f105) 45 CFR 232.47
(f106) Social Security Act, Section 402(a)(26);
IC12-14-2-24; 470IAC10.3-8-1
(f107) 45 CFR 233.20
(f107a) 470IAC10.3-10-1
(f107b) 470IAC10.3-10-1
(f107c) 470IAC10.3-10-1

(f107d)	470IAC10.3-10-1
(f107e)	470IAC10.3-10-1
(f108)	Section 6(o) of the Food Stamp Act of 1977 as amended by Section 824 of P.L. 104 -193 (PRWORA)
(f109)	Section 6(o) of the Food Stamp Act of 1977 as amended by Section 824 of P.L. 104 -193 (PRWORA)
(f109a)	Section 6(o) of the Food Stamp Act of 1977 as amended by Section 824 of P.L. 104 -193 (PRWORA)
(f110)	45 CFR 250.30
(f111)	45 CFR 250.35
(f112)	45 CFR 400.81
(f113)	470 IAC 10.1-1-2
(f114)	45 CFR 250.34
(f114a)	45 CFR 250.30(b)(6)
(f114b)	45 CFR 250.30(b)(6)
(f115)	45 CFR 400.82(b)(3)(ii)
(f115a)	470 IAC 14-3-2
(f115b)	470 IAC 10.3-8-3
(f116)	45 CFR 233.100
(f117)	Social Security Act, Section 402(a)(8); 45 CFR 233.20
(f118)	470 IAC 10.1-3-5
(f118a)	470 IAC 14-2-5
(f118b)	470 IAC 14-2-5
(f118c)	IC 12-14-5.5-1
(f118d)	IC 12-14-5.5-1
(f138)	470 IAC 10.1-1-1
(f139)	470 IAC 10.1-1-1
(f140)	Social Security Act, Section 402(a)(21); 45 CFR 233.106
(f141)	Social Security Act, Section 402(a)(21); 45 CFR 233.106
(f142)	470 IAC 14-2-4
(f143)	470 IAC 14-2-3
(f143a)	470 IAC 14-2-4.1
(F143b)	470 IAC 14-2-4.2
(f144)	470 IAC 14-2-1
(f146)	PROWRA Of 1996 Section 103
(f146a)	470 IAC 14-3-1
(f146b)	470 IAC 10.3-5-10
(f147)	470 IAC 14-3-1
(f148)	470 IAC 14-3-2
(f149)	470 IAC 14-3-2
(f150)	470 IAC 14-3-10
(f151)	IC 12-14-2-25
(f152)	IC 12-14-2-25